

# UROGYNAECOLOGY

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Vol. 25 No.2 | Winter 2023

a RANZCOG publication

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# Guideline recommended MHT

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\*Guidelines recommend transdermal estrogen and micronised progesterone over oral estrogen and synthetic progestins, respectively.<sup>1-7</sup>



ults from two nested case-control studies assessing the association between VTE risk and different types of MHT. Odds ratios are based on cases and controls matched by age and practice, and adjusted for smoking status, BMI, family history of VTE, chronic and recent medical events, other drugs, and past exposures to hormones.

Minimum Product Information Estrogel (estradiol hemihydrate) Indications: Hormone replacement therapy (HRT) for estrogen deficiency symptoms in postmenopausal women. Prevention of osteoporosis in postmenopausal women at high risk of future fractures who are intolerant of, or contraindicated for, other medicinal products approved for the prevention of osteoporosis. The lowest effective dose should be used for the shortest duration. Contraindications: Known, past or suspected breast cancer; Known or suspected estrogen-dependent malignant tumours (e.g., endometrial cancer); Undiagnosed genital bleeding; Untreated endometrial hyperplasia; Previous or current venous thromboembolism (e.g. deep venous thromboembolism); Known thrombophilic disorders (e.g., protein C, protein S, or antithrombin deficiency); Active or recent arterial thromboembolis desease (e.g., angina, myocardial infarction); Acute liver disease, or a history of liver disease as long as liver function tests have failed to return to normal; Known or suspected pregnancy; Lactation; Known hypersensitivity to the active substances or to any of the excipients; Porphyria. Precautions: Appraisal of the risks and benefits should be undertaken at least annually. Refer to full Product information (PI) for conditions which require supervision during treatment with Estrogel. Treatment should be withdrawn if the following occur, jaundice or deterioration in liver function; significant increase in blood pressure; new onset of migraine type headache; pregnancy. **Caution**: endometrial hyperplasia and carcinoma, breast criteria hyperplasia, and carcinoma, breast criteria hyperplasia and carcinoma, breast criteria hyperplasia, wore should be avoided at site of application, metaolism of estrogens may be increased by concomitant use of inducers of hepatic enzymes such as anticonvulsants (phenobarbital, phenytoin, carbamezapine) and arti-infectives (riampicin, rifabutin, nevirapine, efavirenz, ritonavir and nefitavir) and some herbal preparations (SL Johns wort) reducing t Minimum Product Information Estrogel (estradiol hemihydrate) Indications: Hormone replacement therapy (HRT) for estrogen deficiency symptoms in postmenopausal women. Prevention of osteoporosis in postmenopausal

Eg. of the aims and shouldes, and/or initial mighs. The area of application should be as large as possible. Neel to Full Flouder Information Perometrium (oral, micronised progesterone) Indications: menstrual irregularities; adjunctive use with an estrogen in postmenopausal women with an intact uterus. Contraindications: known alleyse as possible. Keel to Full Flouder Information Perometrium (oral, micronised progesterone) Indications: menstrual irregularities; adjunctive use with an estrogen in postmenopausal women with an intact uterus. Contraindications: thrombophlebitis; cerebral haemorrhage; porphyria. Clinically Significant Precautions: not a treatment for premature labour; not a contraceptive; discontinue if unexplained visual loss/changes, proptosis, diplopia, papilloedema, retina vascular lesions or migraine; use caution in conditions affected by fluid retention and history of depression, diabetes, hepatic dysfunction, migraine, photosensitivity and during lactation; increased risk of breast cancer and venous thromboembolism with estrogen concomitant therapy (refer estrogen PI); may cause drowsiness; may affect laboratory test results. Clinically Significant Interactions: caution with P450 enzyme inducers; headache. Dosage and Use: take capsules (100mg/200mg) orally, OD at bedtime without food. Hormone Replacement Therapy: 200 mg/d for 12d (d15–d26) of the cycle; or 100mg can be given from d1–d25. Secondary amenorrhoea: 400mg/d for 10d. Ovulation disorders/anovulation: 200–300mg for 10d (d17–d26, inclusive).

# **Please review Product Information before prescribing,** accessible at besins-healthcare.com.au/PI or 1800 BESINS (237 467) or by scanning the QR code:

BMI: body mass index; MHT: menopausal hormone therapy; OR: odds ratio; VTE: venous thromboembolism.

BMI: body mass index; MHT: menopausal hormone therapy; OR: odds ratio; VTE: venous thromboembolism. References: 1. The 2022 hormone therapy position statement of The North American Menopause Society. Menopause 2022;29(7):767–94. 2. Hamoda H et al. Post Reprod Health 2020;26(4):181–208. 3. Cobin RH et al. Endocr Pract 2017;23(7):869–880. 4. Baber RJ et al. Climacteric 2016;DOI: 10.3109/13697137.2015.1129166. 5. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists. Managing menopausal symptoms; C-Gyn 9. Available at https://ranzcog. edu.au/wp-content/uploads/2022/05/Managing-menopausal-symptoms.pdf; Accessed November 2022. 6. National Institute for Health and Care Excellence. Menopause: diagnosis and management. NICE guideline [NG23]. Available at https://ice.org.uk/guidance/ng23, Accessed November 2022. 7. Stuenkel CA et al. J Clin Endocrinol Metab 2015;100:3975–4011. 8. Vinogradova Y et al. BMJ 2019;364:k4810. 9. Estrogel® (estradiol hemihydrate) Product Information, updated 24 May 2021. 10. Fournier A et al. Int J Cancer 2005;114:448–454. 11. Murkes D et al. Gynecco Endocrinol 2012;28(S2):12–15. 12. Stute P et al. Climacteric 2018 ;DOI:10.1080/13697137.2017.1421925. 13. Prometrium® (micronised progesterone) Product Information, updated 01 February 2022. Estrogel® and Prometrium® are registered trademarks of Besins Healthcare. Besins Healthcare Australia Pty Ltd. ABN 68 164 882 062. Suite 5.02, 12 Help St, Chatswood NSW 2067. Office phone (02) 9904 7473. For medical information call 1800 BESINS (237 467). www.besins-healthcare.com.au EPR-EST-PRM-1665 January 2023.

**PBS Information:** These products are not available on the PBS.









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**PBS Information:** Authority required (STREAMLINED) for Assisted Reproductive Technology and for the prevention of Preterm Birth. Refer to PBS Schedule for full authority. This product is not listed on the PBS for treatment of Threatened Miscarriage.

## Please review Product Information before prescribing. The Product Information can be accessed at besins-healthcare.com.au/PI or telephone 1800 BESINS (237 467).

ART, assisted reproductive technology. References: 1. Utrogestan<sup>®</sup> (micronised progesterone) Product Information, updated 22 February 2022. 2. Australian Public Assessment Report for Progesterone, June 2017. Available at https://www.tga.gov.au/sites/default/files/auspar-progesterone-170601.pdf Accessed February 2023. 3. Besins Data on File. 4. Child T *et al. Reprod Med* 2018;36:630-45. 5. van der Linden *et al. Occh Datab Syst Rev* 2015, Issue 7. Art. No.: CD009154. 6. Devall AJ *et al. Cochrane Datab Syst Rev* 2021, Issue 4. Art. No.: CD013792. 7. The EPPPIC Group. *Lancet* 2021;397:1183–94. 8. Romero R *et al. Am J Obstet Gynaecol* 2018;218(2):161–80. 9. Care A *et al. BMJ* 2022;376:https://doi.org/10.1136/bmj-2021-064547.

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<sup>‡</sup>Evidence from over 35 years of clinical experience across indications, supported by extensive post-marketing safety data, published meta-analyses and systematic reviews.1-9

\*Indicated in the settings of 'Luteal phase support' and 'Support during pregnancy'. Refer to the Product Information for the full details of each indication.<sup>1</sup>



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#### TO FIND OUT MORE VISIT BESINS-HEALTHCARE.COM.AU/EVIDENCE/ OR SCAN THE QR CODE.

Utrogestan 200 (vaginal use – micronised progesterone) Indication: luteal phase support during assisted reproduction; treatment of th women with a history of ≥ 3 previous miscarriages and women with < 3 miscarriages who have a reduced chance of future pregnar women with a history of  $\geq$ 3 previous miscarriages and women with < 3 miscarriages who have a reduced chance of future pregnancy. Benefit of treat was greatest in women with  $\geq$  3 previous miscarriages; prevention of preterm birth in women with singleton pregnancy who have a short cervix (midtrin sonographic cervix  $\leq$ 25 mm) and/or a history of spontaneous preterm birth; Dosage and Use: during luteal phase support in controlled ovarian cycles 60 day as 3 divided doses from day of embryo transfer until 7" week of pregnancy and not later than the 12" week. For treatment of threatened miscarriage, dose is 400 mg twice a day (morning and night). Treatment should be initiated at the first sign of vaginal bleeding during the first trimester of pregnancy and s continue to at least the 16" week of gestation. For prevention of preterm birth, usual dose is 200 mg/day, recommended at bedtime. Treatment can be ini during the 2" trimester (16-24 gestational weeks) and is to be continued to the end of the 36th week of gestation or until delivery. Each capsule of Utrogestan be inserted deep into the vagina. The average dosage is 200 to 800 mg of progesterone per day administered vaginally. This may be increased, depending c patient's response. Contraindications: known allergy/hypersensitivity to progesterone/excipients; severe hepatic dysfunction; undiagnosed vaginal bleeding; k missed abortion/ectopic pregnancy; mammary/genital tract carcinoma; thromboembolic disorders; thrombophilebitis; cerebral haemorrhage; porphryia. S Warnings and Precautions: should only be used by vaginal route for the recommended timeframes for each indicated use (pregnancy Cat A); cytolytic liver dar gravidic cholestasis exceptionally reported during 2<sup>m</sup> and 3<sup>m</sup> trimesters of pregnancy; not a contraceptive; uterine bleeding cause must be established befor discontinue use upon diagnosis of missed abortion; use caution in conditions affected by fluid retention and history of spontaneous pretern birth is lin Interactions; caution with P450 enzyme in







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RANZCOG acknowledges and pays respect to the Traditional Custodians of the lands, waters and communities across Australia, on which our members live and work, and to their Elders, past, present and future.

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RANZCOG recognises the special status of Māori as tangata whenua in Aotearoa New Zealand and is committed to meeting its obligations as Te Tiriti o Waitangi partners.

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# **From the President**

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Dr Benjamin Bopp President

One of the favoured lines of my mother's wisdom is that, as our species evolved, things became much more complicated when we stopped laying eggs! This was then usually followed with an uncomfortably detailed description of what having four children can do.

The theme for this winter edition of *O&G Magazine* is *Urogynaecology*. Though represented as a college subspecialty, this is an area of our profession that overlaps or underpins many others, as is particularly evident when we look at some of the topics covered in this Winter edition, from ultrasound in pelvic assessment to pelvic floor muscles to fistula and injectables.

The Australian Birth Trauma Association will outline their advocacy for prebirth education and pelvic floor awareness and following years of ongoing controversy, very bad publicity, legal proceedings, and government enquiries, we also have updates on mesh, credentialling and pelvic pain. It has been an extremely busy year for our RANZCOG team. Thanks must go to all College staff, Fellows and members who have dedicated so much time and effort to our once-in-a-decade Australian Medical Council and Medical Council of New Zealand reaccreditation process. The volume of work required in formulating our submissions and preparing for the upcoming site visits is truly exceptional.

More broadly, the College has taken the initiative to plan and move quickly to commence construction of an examination centre on two floors of our six-storey 'Djeembana', College Place, in Melbourne.

This infrastructure investment will future-proof our assessment capability by allowing us to conduct examinations in house. We'll also save considerable money on what we have been paying commercial providers and potentially, by charging other educational organisations to use our facility, gain the College another ongoing income stream to support member services.

RANZCOG is reinforcing its international efforts and Memoranda of Understanding with upcoming visits to Malaysia, Indonesia and Sri Lanka by College delegations. President-elect Dr Gill Gibson recently represented RANZCOG at the American College of O and G conference in Baltimore, and I will be speaking at the Canadian conference in Ottawa and Royal College conference in London in the next few weeks. Then it's to Rotorua for the Aotearoa New Zealand conference.

We're looking to the upcoming Sydney symposium in July and the organising committee for our own RANZCOG annual scientific meeting to be held in Perth in late October have also been working hard to prepare for what will be a great event.

Take care, keep safe (and warm) this winter, and please enjoy this issue of your *O&G Magazine*.





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# From the CEO

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Vase Jovanoska Chief Executive Officer

RANZCOG is dedicated to the establishment of high standards of practice in obstetrics and gynaecology, and that includes addressing the needs and individual interests of trainees and supporting our Fellows throughout their careers.

However, we realise that O&G as a profession has had to navigate the failure of systems, lack of research, monitoring and evaluation of new devices and procedures. Use of mesh has had significant consequences for many women. We acknowledge the pain and distress suffered by many Australian and Aotearoa New Zealand women (wāhine) who have experienced complications arising from pelvic mesh implants. We remain committed to working collaboratively with the health system and the wahine and whanau across our moto to contribute to a pathway of care that helps to relieve the burden of urinary incontinence in our community in a safe and effective manner. We are committed to ensuring women are given evidence-based guidance and are offered an appropriate range of treatment options, in line with their own goals and values.

This edition explores urogynaecology-related work, revealing significant developments and new directions in this subspeciality.

#### **Congratulations, Dr Gillian Gibson**

Congratulations to Dr Gillian Gibson as our President-Elect. Dr Gibson will take up her role in November 2023, after RANZCOG's Annual General Meeting. Her term will run to November 2025. Dr Gibson will become the second female President of RANZCOG\*. She will also become the second New Zealander to hold the office. We can be proud of the College's gender equity and diversity journey. RANZCOG exceeded gender targets for female representation on its current Board and Council – 18 of 24 Councillors and five of nine Board Directors are women. There has also been a considerable increase in the female representation and Chairs on various committees and working groups of the College compared with previous years.

I congratulate Gill and am confident her passion and dedication will help deliver the best guidance and support to our Members and trainees across Australia and Aotearoa New Zealand.

#### **College Accreditation**

The Australian Medical Council (AMC) and Medical Council of New Zealand (MCNZ) are well underway into assessing the College's education and training, and professional development programs and activities. Read our Reaccreditation and CPD Homes submissions. I would like to acknowledge the significant contribution to these important pieces of work by College staff, the AMC/MCNZ Accreditation Steering Committee, the Board, and many other Members and trainees. Without their input it would not have been possible to achieve this milestone.

Our submissions are just the start of the College's assessment. Next month (July) the AMC will visit the College during Council Week to meet with relevant



### AGES 2023/2024 **EVENT UPDATES!**

19th August 2023 AGES Laparoscopic Anatomy Pelvic Demonstration Workshop MERF, Brisbane

12th August, 21st October and 25th November 2023 AGES Laparoscopic Anatomy Pelvic Dissection Workshop MERF, Brisbane

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committees and other key stakeholders involved in College governance.

#### **Elective Surgery Backlog**

The COVID-19 pandemic increased pressure on pre-existing, underfunded and under resourced public health systems. Patients are suffering with women being impacted severely. We have called on governments in Australia and Aotearoa New Zealand for urgent funding reform to address the growing number of people waiting for elective surgery. As a result of reduced surgical services for women, O&G trainees struggle to get the surgical experience they need to become confident specialists, with the broad skillsets consumers need and expect. Governments need to investigate and put in place well-funded and formulated arrangements with hospitals, both public and private sector, to ensure O&G trainees, the future workforce, is confident and capable to look after the communities' needs.

#### **Rural Women's Health**

The College has been outspoken in advocating for the equitable delivery of women's health services across Australia, mindful of the unique challenges

rural and remote women face when accessing services. While these have taken years to emerge the need for multidisciplinary solutions is critical.

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It was great to welcome more than 50 delegates representing College Members and trainees, midwifery groups, consumers, and key stakeholders from Commonwealth, state and territory governments, non-government organisations and other service providers who support rural, regional and remote women's health collaboratively, to the College in May for our first Australian rural women's health roundtable. The day examined access to care in regional and rural Australia, barriers to recruitment, lack of support for the health professionals as well as collaboration, training and upskilling opportunities. These discussions will help inform the direction of RANZCOG's Rural Women's Health Strategy.

\* Dr Heather Munro AO was the first and only woman President of the Royal Australian College of Obstetricians and Gynaecologists (RACOG) (1994-1996). The late Associate Professor Christine Tippett AM was the first woman President of RANZCOG (2006 - 2008).

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# LEADERS F CUS



Dr Nisha Khot MBBS, MD, FRCOG, AFRACMA, FRANZCOG

This feature sees Dr Nisha Khot in conversation with women's health leaders in a broad range of leadership positions. We hope you find this an interesting and inspiring read.

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#### Dr Tanaka Dune RANZCOG CU

I first met Dr Dune in the pre-Covid era when specialist international medical graduate (SIMG) interviews were in-person at old College House in East Melbourne. Not all readers may be aware of the process for SIMG assessments by RANZCOG so let me digress briefly to explain this process. I must add that many components of the process are determined by AHPRA/AMC, not RANZCOG. An IMG applies to the College (written submission) with details of their training program, experience and CV. The College appoints assessors who determine comparability of the SIMG's training and experience with that of an Australian-trained specialist O&G. This leads to one of two outcomes: if the program and experience are determined to be comparable, the SIMG is 'eligible for interview'; if determined to be not comparable, the SIMG is 'not eligible for interview' and must apply for a place on the training program as an ITP trainee. The second step in the process is the interview. Pre-Covid these occurred in-person and

SIMGs travelled from all over the world to Melbourne for their interview. Covid made us pivot to online interviews and all SIMG interviews are currently conducted virtually, thus saving time and money while reducing the impact on the environment. The interview is an exhaustive discussion with the SIMG about their training, current practice in O&G as well as an assessment of their 'readiness' to work as a specialist in Australia (or NZ, although the NZ system is slightly different). Following the interview, there is a possibility of one of three outcomes: 'not comparable'; 'partially comparable' and 'substantially comparable' to an Australian-trained specialist O&G. SIMGs who are not comparable must apply for a place on the training program and complete this to be able to practice as specialists. SIMGs who are substantially comparable can commence working as a specialist O&G with supervision (usually for 12 months) before they gain their Fellowship. If determined to be partially comparable, SIMGs need to train (usually in a senior registrar equivalent role) for a further two years, complete a list of requirements (like colposcopy, ultrasound etc) and successfully complete both parts of the Fellowship examination. At this point, a reminder that these are experienced specialists in their own country may go some way towards understanding the uniquely challenging situation for SIMGs.

To return to Dr Dune, readers will now recognise the importance of our first interaction given this interview was a crucial step to practicing as a specialist (or for Dr Dune, as a subspecialist certified urogynaecologist) in Australia. From the start of the interview. Tanaka came across as a confident. capable and outspoken expert in her field. Her passion for women's health and urogynaecology was obvious and I thought to myself how fortunate Australian women would be to have her as their doctor. I quietly hoped that our paths would cross again. Tanaka joined the urogynaecology unit at Royal Women's Hospital (RWH) in Melbourne and although our paths didn't cross physically (a virus saw to it that all 'real' social and professional gatherings became impossible), I followed her progress with interest. Given the focus on urogynaecology in this issue, it seemed a perfect opportunity to catch up with Tanaka and share her experience with readers of this column. In addition to her work at RWH. Tanaka also has a senior research fellow role at Epworth HealthCare's Pelvic Floor Centre of Excellence and has been a supervisor for the University of Melbourne's 2nd year Medical Student MD Research Skills (MDRS2). I hope readers will enjoy getting to know one of the very few dually board-certified urogynaecologists (USA and Australia certified).

### What were your early years like and what prompted your interest in medicine and O&G?

I was born in Harare, Zimbabwe, but I grew up in Canada. I was always a studious kid who loved to learn. I was interested in the sciences and gravitated naturally towards medicine. I did my undergraduate studies in Kingston, Ontario in Canada, and medical school in the southern USA at Wake Forest University School of Medicine in Winston-Salem, North Carolina. I know that medical school can be a daunting experience for some but for me, it was the most exhilarating time of my life. I learned a lot and everything I learned made me excited to learn more.



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From very early on in medical school, I saw myself being most comfortable in a role that would have a combination of hands-on surgery as well as a theoretical/academic component. I always knew that I wanted to uplift women and work in a women's health speciality. O&G was a natural fit for my interests in surgery, academia and wanting to improve women's health.

#### How did you come to choose urogynaecology?

I once saw a plastic surgeon performing a vulval reconstruction in the anatomy lab on a patient who had had vulval cancer surgery. As a naïve medical student, I questioned the need for this reconstruction. The surgeon was very patient and explained the need to maintain integrity of structures and how important this was to the health and wellbeing of the individual. At that time, I thought to myself – this is what I want to do. I want to be able to restore integrity and reconstruct damaged tissue.

My first real experience of working in O&G was as a first-vear resident (also known as an intern) in New York City at St Luke's Roosevelt-Hospital Centre (now Mt. Sinai West). My O&G internship was fast paced, 24/7, go-go-go working 80 hours a week. From New York, I switched programs and went on to the elite program at Northwestern University where I completed my residency in O&G. The total training time to become an O&G in the US is four years. I went directly from four years of medical school to four years of residency. A resident in the US is the same as a registrar in their training program in Australia. During medical school and residency, I started questioning my mentors about pelvic floor reconstructive surgery in O&G. At the time, urogynaecology (also known as Female Pelvic Medicine and Reconstructive Surgery - FPMRS) in the United States was only just becoming formally recognised as a separate subspecialty. The ability for one to achieve board certification in FPMRS occurred for the first time in 2013. My interest in FPMRS piqued during this time, and I made the decision to enter a three-year fellowship program at Loyola University in Chicago led by the foremost leaders in the field, namely Dr Linda Brubaker. My program at Loyola was unique as my program director, Dr Elizabeth Mueller, the immediate past-president of the American Urogynecologic Society (AUGS) was a urologist. This was the first time I saw the synergy between the two specialties working together and it forever changed how I would work.

After fellowship, I joined the department of urology at Weill Cornell Medicine in New York City. I was told that I was likely the first Black woman to be a full-time faculty member and assistant professor in the department of Urology, and an O&G at that. As an O&G in a department of urology, I started from scratch and built my urogynaecology practice and am now well versed in change and adaption. It was an exciting time to be a urogynaecologist, especially in a urology department, and I learned a lot from the experience.

### What has your experience in Australia as an SIMG been like?

Coming to Australia from the US, I knew about the Australia that tourists knew and recognised the beaches, the sunshine, and the relaxed lifestyle. But I didn't know the Australia that can only be experienced by living here as a local. The decision



Dr Tanaka Dune.

to move to Australia was largely due to family. My sister had initially moved to Australia for her PhD, and subsequently, my parents moved in 2013 and they are all based in Sydney. I was making at least two to three trips each year to visit them, since 2013, and it made sense to move closer. My experience of moving to Australia was in some wavs exactly how I expected it to be but in other ways, it was completely unexpected. Visiting a country versus living there are two completely different things. I started working at RWH in Melbourne in February 2020 and was almost immediately in lockdown. In a bizarre twist of fate, I had seen my family more frequently when I lived in New York and Chicago than I did for the first couple of years after moving to Australia! However, Covid really showed me how amazing the public health system in Australia was and how committed my colleagues were to provide exceptional public healthcare. As an SIMG, although I was deemed substantially comparable, there was still the requirement of supervision. This proved to be challenging during Covid, given largely to the cancellation of elective surgery. However, despite the challenges, I completed all the requirements to become certified by RANZCOG in urogynaecology. I am now one of very few urogynaecologists who are certified both in the USA and Australia. I can honestly say that my overall experience as an SIMG is one of gratitude and collegiality. The other refreshing experience of Australia (as compared to USA) is the focus on work-life balance, on family, on leisure, and on a slower pace of life in general without the compromise to patient care.

In Australia, we have regulations and procedures to assess 'comparability' of non-Australian training programs with the Australian training program. This comparability is based mainly on the duration of training. Many non-Australian programs do not compare favourably because they are less than five years duration.

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I can understand the scepticism about non-Australian training programs. The training program in the USA is four years of residency that is both rigorous and intense. It is recognised across the world as a robust program. When we make comparisons, we often centre them around what we are familiar with and what is the norm for us. Now, having had a robust experience of medicine and surgery in the US and Australia, I believe we sometimes think of ourselves, in whichever country we are in, as the standard, instead of having a more global sense of different health systems in which doctors train. If we took a global view, we would have even more collaboration, an intrinsic fundamental understanding that there is more than one way of efficiently and safely engaging in medical and surgical procedures and we could learn that much more from each other as global citizens. As an undergraduate, I remember spending some time in India. From my point of view, I was at an excellent Indian medical school/centre and was getting a whole lot of hands-on experience in research. In India, the interns and undergraduates were doing ten times the numbers of procedures that I had seen being performed in my medical school and its associated training program. This was their normal. It opened my eyes to become more global in my views.

My own journey involved the annual residency 'MATCH' where medical students match directly into their training programs straight out of medical school. The match process is incredible, as you have to apply to a bunch of training programs across the country and if you get an interview and if you make it on the program's rank order list, that program must match your rank order list of the programs you interviewed at. It is an exciting time which means you can end up anywhere in the country and we all find out on the same day – the exciting 'MATCH DAY'. In the US, you must make the decision to specialise very early in medical school because we don't have an inbetween program like the Australian pre-vocational training. As mentioned previously, registrars are called residents in the US, and a first-year resident is called an intern. I worked 80 hours a week for my entire four years of O&G residency, my predecessors worked even longer. At the time, I was only one of 10 Northwestern O&G residents, which increased to 11 by the end of my training, in a hospital that delivered 12,000 babies a year. So you really can imagine the workload for each of us and I learned a lot quickly! Upon finishing my residency, I matched again into a fellowship program right away. Urogynaecology fellowship in the US is three years long at a single institution, where two of these are clinical/surgical vears and the third (which was woven into the three vears) was a full vear of research. As a resident and as a fellow, you learn skills from many different consultants (or attendings as they are called in the US) in a similar apprenticeship model that exists all over the world. There is a fantastic openness to teaching skills but also to allowing individuals to shape their own skillset, especially surgically. Residency and fellowship prepare you for a career as a subspecialist but as with everything in medicine, learning does not stop once you attain fellowship. Unlike Australia, the US requires yearly recertification to be able to continue practicing as a specialist. This recertification is in the form of a minimum required number of articles to be read and quizzed on as well as practice improvement modules. Though this process is relatively simple enough, failure to comply results in a loss of certification. This process is one way of ensuring updated knowledge and the continuation of evidence-based practice. It is likely that the rest of the world will move towards recertification, and we should certainly be prepared for this in Australia.



Wedding reception festivities in traditional African dress.



### Have you experienced racism and discrimination and how have you dealt with it?

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I have a rich background and come from a strong home environment where there was always a complete understanding and acknowledgement of my identity. The loss of identity is well documented in the experiences of African Americans in the USA. I did not have this experience of loss myself. When I presented myself to medical school in the South, I was surprised to find that a few fellow medical students assumed (by coming up and directly telling me) that I was only enrolled as part of a quota for affirmative action. The first time I heard this, I was very affected by it. I had come from Canada to the US as an international student based only on the university's standard entry requirements. The comment made me wonder how many other people in medical school, students and professors alike. looked at me and thought that I was there not on merit but because of a quota that made it 'easier' for me to get into medical school. I started to feel I had something to prove, which was combined with an understanding of why affirmative action was needed in the first place. Further, even if I had been enrolled because of affirmative action, as long as I was doing the work and studied to the standard expectation. what did it matter? For the first time in an academic setting, I realised that I could be seen for my skin colour rather than my skill or my work ethic alone, that is, independent of any trauma and struggles I experienced growing up. This was a critical time in my life, and it was thanks to my family grounding me that I got over the confusion of being seen in a way that was different to how I had grown up and how I had seen myself. But I always acknowledge those who are not able to put the confusion and frustration aside because they experience identity invalidation nearly every day. There is a history and subsequent legacy of the effects of racism in the US that also includes unconscious bias and micro-aggressions towards so many African Americans. When you look at me, I am indistinguishable from an African American and can understand the impact of their experiences of discrimination. Still, I am privileged with knowing who I am, where I come from and easily love my African/Canadian/American, and now Australian, identity

I have lived in Africa, England, Canada, the US and now. Australia. Except for Africa of course. I am always the minority wherever I am. Growing up and well into adulthood I have been called the worst of names to my face in the school setting as a child, those oh so critical years, and in the public arena as an adult. I know that no matter how eloquently I speak, the level of my surgical prowess, how smart I am, I understand I am different, and I will always stick out somewhat. It is the basis of the strength of my upbringing, of my family, my knowledge of where I come from and who I am and my appreciation of all the various bits of my heritage -African, Canadian, American, and now, Australian that makes me recognise myself as 'not other'. If I were to peel back all the layers, I would be a human being first, a wife, a daughter, a sister, an aunty and a friend next, followed by a successful surgeon and academician with everything else thereafter. So, I won't say I haven't faced racism, but what I can say is that I have never let it penetrate my soul or given it a second thought. I am certain many people have underestimated me because of who they see, but I have succeeded because of who I am. This disposition, I know, is my inherent privilege.



Engagement in Lake Como, Italy.

### What is your role in management of major perineal trauma during birth?

I am part of the team that works in the perineal clinic at RWH. Here, we provide multidisciplinary care to women who have sustained major perineal trauma during childbirth, including anal sphincter injury. First and foremost, I want women to know that such a clinic exists and that the team is there to support their recovery as well as their decisions for themselves when it comes to future delivery. I also want to remind women that they have a whole life before and after childbirth. I am a urogynaecologist and I deal with pelvic floor dysfunction resulting directly from childbirth every single day. You might think that I am biased against vaginal birth, but I am not. My role is to support informed decision making and how this will look different for every woman. In addition, I can provide some extra insight into what affects pelvic floor function in the long term due to my subspecialty. We often centre ourselves in the here and now, but I consider my role to be that of reminding women that there's a whole lot of years after childbearing, while maintaining their dignity and right for choice. The decisions made today have sequelae that can affect women many years later and it is our duty to discuss these in detail in a way that makes it easier for them to understand. My ideal is individualised patient-centred care.

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#### What research projects are you currently involved in?

I am involved in about 20 different research projects at present as the senior research fellow at Epworth HealthCare and as an academician in the pelvic floor unit at RWH along with committed team members. The mesh debacle has prompted a resurgence of interest in the use of autologous fascia lata from the lateral thigh instead of mesh for procedures like sacral colpopexy and sacrohysteropexy. I am involved in a number of studies investigating the use of fascia lata in different procedures where mesh has been used.

In addition, I am studying the use of botox for overactive bladder, Bulkamid for stress urinary incontinence, oestrogen for faecal incontinence, early vaginal pessary use for women at high risk of postpartum pelvic organ prolapse, the use of vaginal oestrogen in recurrent UTI and anatomical difference seen in women with recurrent UTI.

### Could you please share your leadership journey with readers?

I was at Weill Cornell Medicine in New York City for three years where I truly began developing my leadership and mentoring skills by overseeing medical students, early career trainee researchers and women in medicine. I was on the Weill Cornell Fellowship program evaluation committee and the clinical competence committee as well as the early research protocol review and monitoring committee. I am an author and a reviewer for several journals including an obstetrics and gynaecology, urology, and urogynaecology/pelvic floor reconstructive surgery. In 2019, I received a distinguished community service and leadership award while at Cornell.

Moving to Australia meant a change in focus to complete the requirements for urogynaecology certification. Having completed this, I am now looking forward to continuing taking on leadership to bolster research in urogynaecology. The next decade of my life will involve acquiring the more holistic hospital-based leadership skills. I want to contribute to the work of RANZCOG and take a more active role in the various committees of the College.

#### What strategies do you have to prevent burnout?

That's an excellent question. I have had to introspect about why I feel burnt out and what works for me. The first key for me is good, clear communication of expectations. Being able to tell my team exactly what I can and can't do, the timeframe in which I can achieve this and to be open to hearing the same from my team members takes away the irritation of missed deadlines and incomplete work that causes burnout. Burnout comes from the lack of communication between the person who is suffering and the people who they believe are the cause of the suffering. This communication is not easy and is affected by power dynamics, lack of agency, and personalities amongst other factors. If we can achieve this communication with empathy, respect and kindness, we will mitigate burnout to a great extent.

The second way I avoid burnout is try and limit procrastination to the best of my ability. If there's something that needs to be done, I get it done. A long to-do list adds to my stress and mental load. I understand that it's not always possible to action everything immediately, but I try my best to get things off my list in a timely manner, so I don't have to carry the extra load of constantly reminding myself of all the things I need to do.

### What are your plans for the short- and long-term future?

My aim has always been to be the best surgeon that I can be. Over the years, I have evolved my surgical techniques as I have learned from senior surgeons both in USA and now in Australia. The thinking that 'we have always done it this way and this way is the best' doesn't hold true anymore and I believe that we should be continuously learning and improving. My long-term aim is to pass on what I have learned to the next generation and train future urogynaecologists.

More immediately though, I am very excited about an upcoming role in Adelaide. I will be the only certified urogynaecologist in a public health service in all of SA. I am working out the details of what this will look like and how I will combine my research interests with clinical and surgical work. Starting something new is always exciting but it can also be daunting. I am approaching it with optimism and a passion for working with both the strengths and gaps that currently exist. I look forward to putting SA on the urogynaecology map of Australia.

#### **Remembering Our Fellows**

Our College acknowledges the life and career of Fellows that have passed away:

- Dr Rosemary (Rosie) Jones
- Dr Sheila Mulvey

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# **Editorial**

Marilla Druitt O&G Magazine Advisory Group

Susan Fleming Te Kāhui Oranga ō Nuku Chair

Oliver Daly Urogynaecologist and Guest Co-Editor

Welcome to our Urogynae issue – the first since our issue of 'Pelvic Floor' in 2014. We have picked the brains of an interesting and diverse group of people – senior and junior, generalists and specialists, nurses and physiotherapists, and patient advocates. Our topics range from grass roots issues – managing bladders after birth, to professional development and systems improvement; exciting developments in research and sobering reminders that whatever our problems, the political will of nations is not fast enough to alleviate the suffering faced by millions of birthing women around the world. Please remember that this is not a book chapter about urogynaecology, not an issue of Current Opinion. Please write to us and tell us what needs to be in the next issue!

All the articles in this issue demonstrate the need for holistic, evidence informed woman-centred pelvic floor care, whether the care is preventative, nonsurgical, surgical or treating complications, and we need to instil this approach in the profession through appropriate clinical and cultural training. This need is no more exemplified than by the controversy, adverse media coverage and political attention arising from the use of mesh in urogynaecology and the emergence of adverse events, most importantly for the patient but also for the profession and society as a whole. It is worth briefly revisiting this history.

In 1996, the early report of 'An ambulatory surgical procedure under local anaesthetic for the treatment of female urinary incontinence' looked very promising,<sup>1</sup> what could be better? While the mid-urethral sling (MUS) may have become the 'gold standard' with a growing body of evidence to support its utility and safety compared to other surgical treatment options, it was initially introduced with inadequate regulatory controls, minimal clinical evaluation, no longer-term studies, no formal surgical training pathways, and minimal credentialing or auditing requirements.<sup>2</sup> This led to a large number of MUS and pelvic organ mesh products being

developed and promoted by industry, and taken up enthusiastically by clinicians, despite importantly different insertion techniques and risk:benefit profiles that have contributed to adverse outcomes.

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As experience with pelvic mesh grew, concerns about its use in the vagina emerged resulting in the first regulatory action in 2008 when the FDA issued a warning,<sup>3</sup> with posterior compartment mesh being a particular focus. By extension, these concerns have now grown to include the MUS with the volume of MUS procedures falling from a peak of over 8000 in 2010 to less than 2500 per year,<sup>4</sup> mirroring the rise in women's concerns about mesh surgery. Their stories gained the attention of the media, lawyers, regulators, and politicians with heartbreaking stories of life-changing physical and psychosocial harms stemming from surgery involving mesh. Consumerled concerns have resulted in litigation, government and parliamentary enquiries, and the withdrawal from the market of the majority of mesh products used in the vagina.2

In the UK, a mesh 'pause' occurred five years ago and shows no sign of being lifted, with mesh only possible under 'a high vigilance pathway' and rarely used.<sup>5</sup> In Australia the 2018 Senate enquiry into mesh<sup>6</sup> led to the formation of Australian Commission on Safety and Quality in Healthcare (ACSQHC) and jurisdictional reference groups, including consumers and a range of experts, resulting in a range of resources to guide clinical practice, such as consumer focused decision tools, care pathways. credentialing guidance, enhanced multidisciplinary meetings, a service model framework and strengthened clinical guidelines.<sup>7</sup> This also led to the establishment of the Australasian Pelvic Floor Procedure clinical quality Registry.<sup>8</sup> In New Zealand, the 2018 enquiry into mesh, under a Restorative Justice framework, led to the establishment of a Mesh Roundtable to oversee agreed actions.9 Progress has been slow and concerned consumers have petitioned the Health Select committee to pause the availability of MUSs. This call is being echoed by the Health and Disability Commissioner, following a surge in complaints, and the Accident Compensation Commission following increasing claims for mesh-related harm and by Health Quality and Safety.<sup>10</sup> It seems inevitable that the availability of MUSs will change and at best be heavily regulated, with significant repercussions on access to SUI surgery for women and reduced ability for gynaecologists outside of a formal urogynaecology training pathway to maintain and develop surgical skills for the treatment of SUI in New Zealand.

More broadly, the perfect storm of the reductions in surgical volume associated with COVID-19 for elective procedures like MUS,<sup>11</sup> withdrawal of pelvic floor products and less experience with older native tissue procedures,<sup>12</sup> and less patient demand for surgery, is having a significant impact on training and maintenance of skills, also affecting geographical equity of access to pelvic floor surgeons. This only increases the challenges for

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those women suffering and seeking care for pelvic floor symptoms. From an evidence standpoint, not only has the withdrawal of products diminished the body of scientific literature for many pelvic floor procedures, in some cases taking us back 30 years, it increases the difficulty of developing evidence for new products. This particularly affects those with complicated or recurrent pelvic floor symptoms needing surgical treatment.

So where does this leave us? Evidence on the long-term performance of MUS, particularly the TVT, continues to be good and the risk of short- to medium-term adverse events is low, although like other surgical approaches, efficacy does fall off over time.13-15 What remains of concern is the small percentage of women who remain with severe symptoms despite further treatment, including mesh removal. Estimates of the proportion of women with severe ongoing symptoms is difficult to ascertain with certainty, varying with the population studied and the measures used. Recent Australian data suggests voiding dysfunction requiring surgical intervention at 3%, rates of excision for mesh exposure or extrusion at 2%, and partial or complete excision for pain 1% at median of 10 years from index surgery.16

Most pelvic floor gynaecological surgeons recommend MUS as an effective SUI procedure,<sup>17</sup> in routine cases, supported by the RANZCOG MUS position statement,<sup>18</sup> with a very low incidence of serious mesh-related long-term problems after treatment, provided women are offered a MUS only after

- a recommendation of supervised pelvic floor exercised by a physiotherapist or continence nurse
- a careful preoperative workup, including urodynamics where appropriate

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- receiving detailed information about the surgical options, not limited by the surgeon's own skillset, including benefits, complications and factors affecting outcomes
- a discussion involving a detailed and fully informed consent, taking into account the patient needs and preferences

and are operated on by well-trained, credentialed surgeons with prospective auditing of clinical and patient reported outcomes. While the incidence of complications may be low, those who do report problems need clinicians to take their concerns seriously, investigate them appropriately and refer them on to others if they are unable to find a solution.

There are many lessons in this mesh journey. We need to ensure we are keeping the patient at the centre of care, that clinicians can develop and maintain their surgical skills to continue offering MUS procedures where indicated and equitably, and that we take a more judicious and evidence-based approach to the introduction of new techniques and products before adoption into routine clinical practice. Current clinical care and patient-reported outcomes should also be captured using audit tools or a quality register to support real-time evaluation of care delivery; and that clinicians must actively engage with their patients as partners in their care.

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# Examining the female pelvic floor

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Hannah Orr MBiomedE, PostGradCert (Pelvic Floor Physiotherapy), BHSc (Physiotherapy) Pelvic Health Physiotherapist Ascot Women's Clinic

The purpose of a pelvic floor examination is to make sense of the patient's experience. It works symbiotically with the subjective assessment to better understand the structural and functional changes that might be contributing to symptoms. It is generally guided by the patient's history, and so as not to require an entire book, a more general examination has been described below as a basic framework to direct appropriate interventions for diagnosis, treatment, rehabilitation, and the promotion of health.

Informed consent is a pre-requisite to any medical examination and although I will not detail this process here, I cannot overstate the importance of ensuring careful consideration for the psychological safety of the patient as well as the safety of the practitioner when doing pelvic floor examinations.

A pelvic floor examination starts with a visual inspection of the vulva. It will often require gently parting the labia for a complete view; remember to clearly state what you are doing before you do it, as people feel before they hear.

#### Visual observation

#### Perineal skin assessment

Looking for presence of scars, lesions, fissures, trophic changes, color, erythema, swelling etc

#### **Perineal body length**

< or > 3cm. This a useful screen for OASIs risk in primiparous women between 35–37 weeks of pregnancy.<sup>1,2</sup>

#### Perineal body position at rest

Palpate the ischial tuberosities (IST) and assess the position of the perineal body in relationship to the IST. Ideally the perineal body is sitting at or just above the IST.

A descending perineum would sit below the IST at rest and suggests reduced pelvic floor support. An elevated perineum is significantly indrawn at rest, suggesting increased tone in the pelvic floor muscles.

#### **Anal gaping**

Non-coaptation of anal mucosa at rest.

This would suggest loss of normal anal sphincter resting pressure and has implications for anal control.

#### **Visual observation continued**

The next stage of visual observation involves assessing the dynamic function of pelvic floor muscle support, including contractile ability and distensibility.

#### Voluntary contraction of the pelvic floor muscles

Ask the patient to contract the pelvic floor muscles (common cues: 'squeeze and lift around your back passage like you are trying to stop wind' or 'squeeze and lift like you are stopping the flow of urine'). An ideal contraction will result in a ventral-cranial movement of the vulva, perineum, and anus; you might also notice closure of the urethral meatus and a clitoral nod.

If there is no movement this might indicate a motorcontrol issue, a very weak muscle or can suggest a high-tone muscle, especially if combined with a perineal body that is sitting high at rest. Descent of the perineum indicates an incorrect technique with overuse of the abdominal muscles which can contribute to incontinence and prolapse symptoms.

#### **Relaxation of the pelvic floor muscles**

Return of the perineum to its resting position.

Observation of non-relaxing, partial, or delayed relaxation can indicate an overactive pelvic floor muscle which can contribute to symptoms such as pelvic pain, obstructed voiding or defecation symptoms and dyspareunia.

#### Perineal movement with bearing down/straining

Ask the patient to bear down/strain as if passing a bowel motion. A small amount (~1cm) of caudal descent of the perineum is expected.  $( \mathbf{ } )$ 

> 3cm of descent below the IST is considered excessive and will potentially contribute to obstructed defecation and prolapse symptoms. Cranial movement of the perineum suggests a dyssynergy and can cause symptoms of obstructed defecation.

#### Genital hiatus on straining/bearing down

Length from urethra to the perineal body on straining. This provides a useful measurement of pelvic organ support and risk of prolapse/ prolapse development.

The relative incidence of prolapse is nine times higher for women with  $Gh \ge 3.5 cm versus \le 2.5 cm.^3$ 

#### Perineal movement with a cough

Observe perineal movement with a voluntary cough. Ideally the pelvic floor muscles pre-contract and there is minimal caudal descent.

If you notice caudal descent with a cough, ask the patient to contract their pelvic floor muscles and keep them contracted while coughing. This is called 'the knack' and has been shown to reduce leakage in around 80% of women with SUI.<sup>4</sup>

#### **Prolapse assessment**

A disassembled bivalve speculum or a tongue depressor covered in a glove is used to draw back the posterior or anterior vaginal wall during the examination. The patient needs to strain/bear down for 6–8 seconds.

The hymen is used as a reference point for quantifying the prolapse using the POP-Q system.

**Stage 1:** The most distal portion of the prolapse is more than 1cm above the hymen.

**Stage 2:** The most distal portion of the prolapse is between 1cm above and 1cm below the hymen.

**Stage 3:** The most distal portion of the prolapse is more than 1cm below the hymen but no further than 2cm less than the total vaginal length.

**Stage 4:** Represents complete procidentia or vault eversion.

#### **Palpation**

Note: the following describes assessing the pelvic floor muscles using a vaginal approach but when this is not indicated similar information can be gained from a rectal examination.

#### Sensation

A quick screen can just include light touch but if concerns assessment of sharp, blunt and temperature might be indicated.

Absence or altered sensation bilaterally/unilaterally suggest compromise in the s2–s4 nerve distribution.

#### **Cotton swab test**

A test for vestibular tissue sensitivity. The test is performed with a cotton swab, gentle pressure is applied around the vestibule in a clockface pattern.

The test is positive if gentle pressure reproduces pain. Often associated with superficial dyspareunia, difficulty with tampon insertion. Pain confined to the posterior vestibule suggests that a high-tone pelvic floor muscle is a major component.

#### **Scar palpation**

Palpate any scar tissue on the perineum and assess for tenderness/pain and tissue restriction.

#### Superficial pelvic floor muscles (Bulbospongiosis)

This muscle is located at the entrance of the vagina. Place the palmer surface of the examining finger on the thickest portion of the muscle belly (4–5 o'clock, 7–8 o'clock; see Figure 1). Assess for tolerance to pressure, reproduction of symptoms, ability to contract, relax and flexibility.



Figure 1. Superficial Pelvic Floor Layer.<sup>5</sup>

Tenderness, pain or increased stiffness can potentially contribute to dyspareunia and the sensation of difficulty with penetration or tampon use. The pudendal nerve supplies the superficial pelvic floor muscles along with the external urethral and anal sphincter, an absent contraction can suggest potential compromise of the pudendal nerve. This has implications for bladder and bowel control.

#### Deep pelvic floor muscles (levator ani)

The levator ani is palpated lateral to midline between 7 and 11 o'clock on the patients right hemipelvis and between 1 and 5 o'clock on the patients left. Insert the examining finger 1–2 knuckles (2–4cm) into the vagina (Figure 2). If the patient has pain symptoms, starting on the right side is recommended as the left is often more tender. Apply gentle pressure and assess for any tenderness or symptom reproduction. Tone can also be assessed by resistance to pressure. Assess quality of contraction and relaxation.



Figure 2. Deep layer of pelvic floor muscles.<sup>5</sup>

The muscles are considered impaired if palpation is painful, they cannot contract, or if they do not relax after a concentric contraction. Monitoring for accessory muscle use such as excessive abdominal wall contraction, adduction, posterior pelvic tilt, breath holding as this may indicate the need for physiotherapy input to optimise technique.

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#### **Obturator internus**

The obturator internus is an external rotator of the hip. To find this muscle, place the index finger in the vagina to the depth roughly just past the second knuckle at 9–10oclock or 2–3oclock on the patients right or left side. Location accuracy can be confirmed by placing their external hand on the patient's lateral knee and asking the patient to push their leg into this hand. This motion will result in the obturator internus contracting under the internal finger.

This muscle can cause referred pain at the ischial tuberosities, coccyx, buttocks, abdominal wall and contribute to symptoms of deep dyspareunia.

#### Levator ani avulsion

This can be assessed by placing the palmer aspect of examining finger between the side of the urethra and the levator ani insertion on the posterior pubic bone. Ask the patient to contract and you are feeling for the edge of the contractile tissue of the levator muscle. Ideally muscle bulk is felt on the side of the finger and equal on both sides.

Levator ani avulsion has implications for pelvic floor muscle strength and can predispose to prolapse symptoms and incontinence.

#### Assessment of strength

This can be done with a single digit or, in parous women with no pain symptoms, a second finger might be added. The patient is cued to contract their pelvic floor muscles and ideally a squeeze and lifting sensation is palpated. The simplest scale to use is the ICS scale (absent, weak, and moderate) but for a more qualitative scale the modified oxford scale is recommended).

Minimal or absent contraction in conjunction with increased muscle stiffness or pain can suggest a hightone muscle rather than a weak muscle.

#### **Assessment of co-ordination**

Ask the patient to cough and assess for precontraction of the pelvic floor muscles.

As stated previously, 80% of women with SUI showed a reduction in leakage by simply being taught 'the knack' (pre-contraction of the pelvic floor muscles before rises in intra-abdominal pressure such as cough).<sup>4</sup>

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CCG MAGAZINE



# The painful bladder

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### The current situation

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Interstitial Cystitis/Bladder Pain Syndrome (IC/BPS) is a clinical and cystoscopic diagnosis, based on pain in the bladder and/or pelvis, associated with severe urinary frequency, urgency and nocturia, and following the exclusion of confusable disorders described below.<sup>1,2</sup> Patients are often severely distressed, as GPs find that the urine culture is sterile, but often are unaware of the possible diagnosis of IC/BPS. Therefore, patients can see multiple gynaecologists or urologists prior to diagnosis, which is readily confirmed by urogynaecologists, as this condition is an important part of the urogynaecology trainee curriculum. Treatment is tailored to the severity of disease and patient response.

### Diagnosis: history, bladder chart, examination and cystoscopy with refill examination

IC/BPS is defined by the European Society for the Study of Interstitial Cystitis (ESSIC) as chronic (>6 months) pelvic pain, pressure, or discomfort perceived to be related to the urinary bladder, accompanied by at least one other urinary symptom such as persistent urge to void or frequency/ nocturia. The pain is triggered by bladder filling (because patients have a small bladder capacity) and usually relieved by urination. Nocturia is virtually always present because the small bladder capacity and pain on filling wakens the patient to toilet.

The bladder chart is an essential part of diagnosis, a typical example is shown in Figure 1, i.e. very small volumes, short voiding intervals (patient voided 11 times/day, 5 episodes of nocturia). Physical examination may reveal tenderness on palpation of the trigone (just above the cervix/vault) but should also be performed to exclude 'confusable diseases' such as pudendal neuralgia, endometriosis and vulval pain. Patients may also exhibit spasm of the levator muscles in the pelvic floor on palpation. The absence of urinary tract infection should be confirmed.

Cystoscopy must be performed under general anaesthesia by those experienced in diagnosis and bladder biopsy (because the maximum bladder capacity cannot be measured under local DATE CHART RECORDED 12 106112

#### BLADDER CHART – DAY 2

TIME	AMOUNT & TYPE OF FLUID IN	TIME	AMOUNT OF URINE PASSED	COMMENTS EG leakage, urge, pain, burning etc.
		6:05	75 ml	
		8:05	50m1	
8:25	200ml Water	9:07	75m/	
8:55	25anl cappee	9:35	100ml	
	90	9.55	looul	
		10:00	1000	Jeaking
		12:50	50 ml	Pleasing
18:50 ,	20ul Apple juice	16:00	100 ml	9
5:40	200ml Cola	1755	Goul	
7:40.	3 Cola	18:55	50 ml	
		20:30	50 ml	
		21:95	50 ml	
		21:55	25 We	
		22:30	20 rul	
		20:40	50 ml	
	0	02:05	20 ml	
			0	-

Figure 1. Typical frequency volume chart of a BPS/ IC patient: small amounts with short time intervals between voids.

anaesthetic, patients will not tolerate the procedure). The technique has been standardised by ESSIC.<sup>2</sup> It involves cystodistension ('hydrodistension') to assess for bladder capacity, followed by a refill examination to observe glomerulations, waterfall haemorrhages, and Hunner's ulcers (now called Hunner's lesions). Glomerulations can be found in patients without IC/ BPS and alone is not diagnostic.<sup>3</sup> In 1915, Hunner described bladder ulcers (now referred to as lesions), appearing as a patch of red mucosa with small vessels radiating to a central pale scar.<sup>4</sup> Bladder filling can also cause mucosal splitting in IC patients. Biopsy can assist in evaluating for inflammation, ulcer, fibrosis, and presence of mast cells - histological features associated with IC/BPS, which are more likely in the Hunner Lesion Disease (HLD) subtype.<sup>5,6</sup>

Although the name Interstitial Cystitis has widely been replaced by Bladder Pain Syndrome, these terms have been used interchangeably in medical literature. The 7<sup>th</sup> International Consultation on Incontinence recommends IC/BPS as the preferred terminology and that there should be no distinction, as has been previously suggested.<sup>1,8</sup> There is recent emphasis on distinguishing HLD as a distinct phenotype, and that this should be determined for the purpose of clinical trials and to guide treatment.<sup>5,7,9</sup> Cystoscopy is essential to delineate HLD vs non-HLD and exclude other disorders and thus we recommend routine cystoscopic evaluation, in contrast to the recent American Urological Association guideline.<sup>10</sup>

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Figure 2A. Glomerulations seen on refill. cystoscopy

Due to variation in terminology and diagnostic criteria, there are discrepancies in the literature regarding the prevalence. Current estimates are that it occurs in 300 per 100,000 women, with a higher prevalence in women than men.<sup>11</sup>

#### **Etiology**

There are numerous theories as to the cause. There is evidence of an immune response, with activation of mast cells which secrete inflammatory mediators.<sup>12,13</sup> Increased permeability of the urothelium due to damage to the GAG layer has also been demonstrated.<sup>14</sup> This may cause pain due to reduced protection from the noxious contents of urine.<sup>15,16</sup> Patients with IC/BPS have also been shown to have elevated anti-proliferative factor levels in urine, resulting in reduced cell production.<sup>17,18</sup>

#### Initial management if suspicion of disease

The role of the primary care physician is crucial. It is important to consider IC/BPS and refer patients when there is unexplained bladder pain. Patient symptoms should be believed, and a bladder chart requested when the urine culture is negative. Symptoms can cause sleep deprivation, reduce quality of life and a patient's ability to function and work. This can have financial implications. There is an association with anxiety and depression. Dyspareunia or fear of intercourse is common, with resulting effects on relationships. Non-bladder syndromes and pain outside the pelvis commonly co-exist. These include inflammatory bowel disease, allergies, irritable bowel syndrome, fibromyalgia, endometriosis, depression, and vulvodynia. The reason for this is unclear.<sup>19,20</sup>

Patient education is first line and involves explaining normal bladder function. Behavioural modification includes timed voiding, controlled fluid intake to avoid concentrated urine and dietary changes. An oxalate-free diet has shown some benefit. Acidic food and drink, coffee, spicy food, alcohol, and foods high in oxalates may aggravate symptoms, to varying degrees.<sup>21,22,23</sup> It is recommended that each patient experiment in finding foods that aggravate symptoms and avoid these. See weblinks such as the IC Association at www.ichelp.org and National Institute of Diabetes and Digestive and Kidney Diseases at https://www.niddk.nih.gov/health-information/ urologic-diseases/interstitial-cystitis-painfulbladder-syndrome for patient information.

In patients who are found to have spasm or hypertonicity of the pelvic floor muscles on physical exam, pelvic floor therapy including myofascial trigger point release and Thiele massage can assist





Figure 2B. Hunner's lesions.<sup>7</sup>

in managing pain.<sup>24</sup> Stress and depression have been shown to occur in a higher proportion than in the general population. Treatment of this with mindfulness, counselling and medication is important in improving quality of life.

Amitriptyline is a tricyclic antidepressant which blocks H1-histaminergic receptors whilst stabilising mast cells. It may also have beta-adrenergic action, enhancing bladder storage. It is commenced at 25mg daily and titrated up to 100mg, though has sedative effects.<sup>25</sup> Impramine 25–50mg can also be used. Studies have demonstrated small benefit from antihistamines such as hydroxyzine and cimetidine.<sup>26,27</sup> Neuropathic analgesics such as gabapentin and pregabalin have been shown to reduce bladder hypersensitivity in animal models.<sup>28,29</sup> Non-opioid analgesics should be used.

#### **Urogynaecology management**

Following diagnosis, treatment options include conservative therapies, oral medications, intravesical instillations and surgical management. We recommend that patients be referred to a urogynaecologist to ensure appropriate diagnosis and management.

Hydrodistension is always performed as part of the diagnostic cystoscopy, and can give short term improvement in a minority. Cystoscopic fulguration or diathermy of Hunner lesions has been clearly shown to result in symptomatic improvement.<sup>30</sup> Injection of the corticosteroid triamcinolone to Hunner lesions has been shown to have comparable results to fulguration in small experimental studies.<sup>31,32</sup>

Dimethyl sulfoxide (DMSO) is the only intravesical agent approved for treatment of IC by the FDA. Side effects include a garlic-like odour for up to 24 hours and approximately 10% of patients report a flare which resolves, thought to be due to mast cell degranulation. 50% DMSO is instilled and retained for 20 minutes, sometimes along with a heparin, lidocaine, or steroid mix.<sup>34</sup> This is repeated weekly for 6–8 weeks. Repeat courses can be undertaken for those who have a good response. Heparin can be instilled on its own and is thought to have similar properties to the GAG layer. Other instillations include hyaluronic acid, chondroitin sulfate, a combination (laluril) or chlorpactin.

Oral cyclosporine has been shown to be effective, particularly in those with HLD.<sup>33</sup> Use needs to be closely monitored due to its adverse effects. There is no evidence to support efficacy from other types of immunosuppressant medications.

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Sodium pentosan polysulfate (PPS/Elmiron) is an expensive (approximately \$140/month) oral treatment, 100mg TDS, used for at least six months. It is a synthetic sulphated polysaccharide excreted into the urine, thought to replenish the GAG layer. It is the only oral drug currently approved by the FDA. It also has antihistaminic and possible anti-inflammatory roles. Recent reports have demonstrated a risk of pigmentary maculopathy from long-term exposure and regular ophthalmology review prior to and during treatment is recommended.<sup>35</sup> There are conflicting findings from trials regarding its efficacy.<sup>36</sup>

There is some evidence of benefit from intravesical botulinum toxin; however, studies so far have included small numbers of participants.<sup>37</sup> Sacral nerve stimulation is still considered an investigational procedure for IC/BPS, there may be benefit in select patients.<sup>38</sup> It is recommended that long-term outcomes should be collected and reported. There is limited data to suggest efficacy of percutaneous or transcutaneous tibial nerve stimulation.<sup>39,40</sup>

Major reconstructive surgery should only be considered in cases where all other treatment options have failed. Bladder augmentation cystoplasty using bowel can improve storage and reduce pain. Risks include recurrent urinary tract infections, metabolic changes, and malignancy. Urinary diversion with or without cystectomy through creation of an ileal conduit or a continent diversion are options where cystoplasty is unsuccessful.<sup>41</sup>

#### **Future research**

Unfortunately, IC/BPS is a condition where much remains unknown. Further research is needed on its pathology, so that we can better understand why and how it occurs. Improved understanding of subtypes of the condition, as well as research into new treatment options, is greatly needed.

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# Severe perineal trauma

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### Navigating the postpartum and beyond: a NZ perspective



Dr Louise Tommlinson Consultant Gynaecologist

Perineal trauma is sustained in over 85% of all who have a vaginal birth. Maternal birth injury has been rising over the past three decades in New Zealand. Reasons for this rise are multifactorial including: increased recognition, improved training in perineal trauma assessment, changing demographics of pregnant women with increasing maternal age, ethnic diversity, larger babies and changes in obstetric practices.

Over this time, a greater understanding has allowed us to identify those with risk factors who are most at risk of perineal trauma, implement preventive strategies to reduce perineal trauma, both in the index delivery and in future deliveries, to minimise further physical trauma with a recurrent anal sphincter injury and psychological harm and regret.

The classification of perineal trauma was initially described by Dr Abdul Sultan in 1999,<sup>1</sup> and has been widely adopted internationally:

- First-degree tear: Injury to perineal skin and/or vaginal mucosa.
- Second-degree tear: Injury to perineum involving perineal muscles but not involving the anal sphincter.
- Third-degree tear: Injury to perineum involving the anal sphincter complex:
- Grade 3a tear: Less than 50% of external anal sphincter (EAS) thickness torn.
- Grade 3b tear: More than 50% of EAS thickness torn.
- Grade 3c tear: Both EAS and internal anal sphincter (IAS) torn.
- Fourth-degree tear: Injury to perineum involving the anal sphincter complex (EAS and IAS) and anorectal mucosa.

Following delivery, recognition and repair of an obstetric anal sphincter injury (OASI) and appropriate follow up is essential. It is important to address both physical and psychological trauma.

Significant progress has recently been made in New Zealand with changes in legislation. Accident Compensation (ACC) is a Crown entity that provides aid with health, rehabilitation and service provision to any New Zealander or visitor to New Zealand who has sustained an injury. From 1 October 2022, ACC recognised maternal birth trauma as an injury and cover is now available automatically for all birth parents who meet the criteria (see below). This includes early access to pelvic floor physiotherapy, referral to specialists if necessary, psychological support and home help.

The postpartum period is defined by ICS/IUGA terminology paper 'from delivery to 12 months after delivery', recognising the longevity of pelvic floor healing over this time.<sup>2</sup>



He Kaupare. He Manaaki. He Whakaora.

#### prevention. care. recovery.

#### Covered maternal birth injuries

Anterior wall prolapse, posterior wall prolapse, or uterine prolapse

Coccyx fracture or dislocation

#### Levator avulsion

Obstetric anal sphincter injury tears or tears to the perineum, labia, vagina, vulva, clitoris, cervix, rectum, anus, or urethra

Obstetric fistula (including vesicovaginal, colovaginal, and ureterovaginal)

Obstetric haematoma of pelvis

Post-partum uterine inversion

Pubic ramus fracture

Pudendal neuropathy

Ruptured uterus during labour

Symphysis pubis capsule or ligament tear



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### Management of subsequent pregnancies: what do we know and what questions remain unanswered?

Ideally follow up after severe perineal trauma should be in a dedicated multidisciplinary setting, with an obstetrician/gynaecologist or urogynaecologist with a special interest in obstetric trauma and a women's health physiotherapist, with colorectal input.

Concerns for birth parents with a history of OASI include the risk of recurrence of an anal sphincter injury and the risk of worsening anal incontinence. Individualising care is imperative, addressing clinical symptoms and unfortunately few places in New Zealand routinely offer adjuvant imaging, either transperineal ultrasound (TPUS), endoanal ultrasound (EAUS) or anal manometry (AM), to assist with planning future pregnancies. Given these limitations, how can we counsel women adequately?

Clinical symptoms are poorly predictive at identifying structural integrity of the anal sphincter complex. A metanalysis in 2020 by M Sideris et al, showed that following primary repair, 55% had a persistent sphincter defect, with 38% experiencing anal incontinence. Of concern, in the group of women without clinical suspicion of OASI, 13% had a defect on EAUS and 14% experienced anal incontinence.<sup>3</sup> Vigilance is therefore necessary when giving advice regarding mode of delivery with any birth parent who has had a previous vaginal delivery, as a missed OASI may have been sustained. When symptoms are compared with grade of tear, those that have sustained a 3C and fourth degree tear have a significantly higher rate of anal incontinence compared to those with a 3A tear.4

A study in 2020 by A Taithongchai et al reviewed 74 patients with fourth degree tears. 61% were asymptomatic. Endoanal scanning identified an internal anal sphincter defect in 77% and external anal sphincter defect in 49%. This confirms the presence of symptoms alone are poorly predictive of a sphincter defect. Based on RCOG guidance, in this cohort of patients only 7% would be offered a vaginal birth, i.e. asymptomatic with a normal scan and manometry findings. When imaging is not possible, birth parents with major OASI injuries (3c/4th degree trauma) should be offered an elective caesarean section.<sup>5</sup>

Croyden University Hospital share 11 years of their experience running a perineal tear clinic, which provides useful guidance for our setting. Their clinics would include:<sup>6</sup>

- A detailed history including demographic data (age, parity, ethnicity), mode of delivery, obstetric details, degree of perineal trauma, and presence of vaginal, urinary and bowel symptoms. Severity of anal incontinence was assessed using the validated modified St. Mark's incontinence score. Urinary incontinence was assessed using the validated International Consultation on Incontinence modular Questionnaire for Incontinence-Short Form (ICIQ-UI\_SF).
- A vaginal examination to assess wound integrity, size of the perineal body (cm) and pelvic floor muscle contraction using the Modified Oxford Scale.
- Appropriate investigations such as anal manometry (AM) and endoanal ultrasound scan (EAUS). These were performed in all women with a history of OASIs.

CARE BUNDLE

#### **The OASI Care Bundle**



#### **Risk of recurrence of OASI**

In a multi-centre retrospective cohort study of 2,272 women with a history of OASIS, 10% suffered a recurrent OASI. Positive predictors for the risk of recurrence included increased birth weight and maternal age at both the index and subsequent delivery, a more severe degree of initial OASI and Asian ethnicity. Of particular note, a mediolateral episiotomy (MLE) rate of 15% was recorded in subsequent deliveries, and 77% of those who had an episiotomy sustained no additional perineal trauma. MLE decreased the risk of recurrence of OASI by 80%, suggesting a more liberal use of mediolateral episiotomy in women with a history of OASI could significantly reduce the risk of recurrence.<sup>7</sup>

Numerous prevention models internationally have been initiated since the early 2000s, following Norway's intervention program that showed OASI rates could be reduced with preventative strategies. UK's OASI care bundle includes antenatal discussion about OASI, manual perineal protection, mediolateral episiotomy at 60° from the midline, and systematic examination of the perineum, vagina and anorectum after vaginal birth. Australia's 'Please Squeeze' has also been shown to reduce maternal birth trauma.<sup>8.9</sup>

To date, there have not been any predictive models to specifically identify women at risk of OASI; however, birth parents who sustain OASI are at risk of pelvic floor dysfunction and many are familiar with UR-CHOICE, a predictive model identifying women with a risk of future pelvic floor dysfunction. This scoring system is based on several major risk factors (urinary incontinence before pregnancy, ethnicity, age at birth of first baby, BMI, family history of pelvic floor dysfunction, baby's weight and maternal height). This model is based on moderately robust epidemiological data at 12 and 20 years after delivery.10 It may be a useful adjuvant during the counselling process, but caution should be used when counselling a birth parent with a maternal age above 34, as the risk assessment tool has no comparable data.

In conclusion, when counselling birth parents who have sustained an OASI injury, an awareness of the limitations when using a risk-based or symptom-based approach is imperative. Birth parents who are symptomatic of anal incontinence and those with major 3c and fourth degree tears should be offered an elective caesarean section. Individualising care for those women with 3A and 3B tears remains the recommendation regarding

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subsequent mode of delivery. Birth parents who, after adequate counselling, choose a vaginal delivery will benefit from preventative strategies at delivery. Consideration of a mediolateral episiotomy, manual perineal protection, choosing a ventouse over forceps if an assisted delivery is required and an early recourse to caesarean section if an obstructed labour is anticipated are all important elements to discuss. With a shared decision-making process, regret in the longer term can be minimised.

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#### The Australasian Birth Trauma Association (ABTA) is the peak charity in Australia dedicated to helping to prevent, diagnose, and treat birth-related trauma.

We collaborate with parents and a wide range of health professionals to raise awareness, provide support and education, conduct research, and advocate for change.

ThinkNatal<sup>™</sup> Education offers a comprehensive range of resources designed to address a wide range of topics that may not receive sufficient attention in traditional birth education. We aim to provide expectant parents with the information and support they need to make informed decisions and take an active role in their care.

We believe in a collaborative, individualised approach to pregnancy, birth, and postpartum care that acknowledges each person's unique life experiences, values, needs, and physical health requirements. We encourage health professionals to adopt the same philosophy.

**Contact Us** 



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CCG MAGAZINE

# Your normal isn't our normal

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Amy Dawes CEO Australasian Birth Trauma Association

Through my own personal experience and as a cofounder and CEO of the Australasian Birth Trauma Association, I have seen and continue to see the devastating consequences that birth injuries have on the lives of those impacted.

In 2015, at 16 months postpartum, I received a diagnosis that altered the course of my life. I had been experiencing symptoms of prolapse (although I didn't know it then), I went to see a pelvic health physiotherapist and through palpation, she diagnosed me with a bilateral levator avulsion. My pelvic floor muscle was torn off the bone, likely due to the forceps delivery of my daughter. The next most devastating part of that diagnosis was being told that surgery isn't viable and that I should modify my lifestyle to avoid making things worse. I walked into that appointment one woman and left a completely different person. I lost my sense of identity, I felt broken and alone. I used to wish I had lost a limb because then people would see my suffering.

This is the problem with birth injuries, because you can't see them, no one knows how much you're suffering. Unfortunately, once women leave the hospital, there are no clear care pathways for them to follow, even if injuries are identified at the time of birth.

I wanted to be sure of my diagnosis, my physiotherapist mentioned that a urogynaecologist would be able to do a 3D/4D ultrasound; however, seeing my distress, she encouraged me to hold off because the treatment plan would likely remain the same. Instead, she connected me with other women who were further along in their own journeys of navigating early parenthood with birth injuries. Speaking to another person that understood how I felt made a difference. Whilst it didn't change my situation, it gave me a sense of hope for the future and helped me make sense of my situation.

As professionals working with birthing women, you will see varying degrees of distress, and how you respond to this distress is so important. Every day we hear stories from women who have sought support for the symptoms, and their concerns are dismissed as 'normal' or 'to be expected after having a baby'. What I need you to know is that their 'new normal' may still cause significant impacts on their quality of life. This was a striking feature of the narrative responses in our 2022 Birth Injuries report, how common it was for women to be dismissed or not believed when they reached out for help. Women report feeling confused, dismissed, anxious, neglected, disappointed, unimportant, in limbo and let down by multiple failures to be helped.

It is difficult to have good mental health when you are navigating life with ongoing physical symptoms such as pain, incontinence or pelvic organ prolapse. Nine out of 10 women in our report indicated that their injuries impacted their mental health. While women reported experiencing postnatal depression and anxiety, many were experiencing symptoms of Post-Traumatic Stress Disorder. We need clinicians to understand when they meet an individual, they are not just a diagnosis but a real person with possible trauma. It is common for parents that have experienced birth-related trauma to lose trust in the medical profession; some will delay vital treatment to avoid returning to the hospital.

We must strive to improve the quality of care provided to women with birth injuries and create a safe and supportive environment where they can share their experiences and seek help without feeling dismissed or unheard. You can read the full report here, and I encourage everyone to do so to gain a better understanding of the issue. You don't have to know all the answers to the questions, but you do need to know where to send them for support.

I reached out to members of the ABTA community to ask for experiences with urogynecologists. My hope is that we can learn from these stories.

### Interactions with urogynaecologists: consumer perspectives

#### **Tara Aguayo**

My first experience with a Urogynecologist was at five months postpartum after being referred by my physio. I prepared a list of questions and counted the days to my appointment in hopes of finally getting some clarity. My husband and I waited over an hour for our appointment, desperately trying to keep our unsettled baby calm, breastfeeding in the waiting room for what felt like eternity.

The visibly flustered and irritated doctor called us in and immediately asked about the details of the birth. Still wrapping my head around the day I nearly lost my life and was left with life-altering injuries, I answered their questions. Tears emerged as the appointment shifted to a disproportionate focus on my appraisal of the birth. With a cold demeanour, I was told that my level of distress about my injuries was 'not normal' and that I was 'depressed'. I felt flushed with humiliation and rage, and it was clear

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that these doctors had never put themselves in the shoes of their patients. I wondered if perhaps they were inherently defensive as their decisions and use of instruments as an obstetrician were likely causing the same outcomes for other women. The doctor examined me in a rushed manner, abruptly told me that I was there 'too early', and told me to come back in a year or two. Perplexed, as their office knew how far postpartum I was, I left with very few of my questions answered and feeling remarkably worse than when I arrived.

I visited four more urogynecologists over the following two years. All but one displayed varying degrees of indifference, inattentiveness, and a lack of empathy. Learning to hide my emotions, I mentally prepared myself each time for care which I knew would be lacking at best. I wondered how so many of these Urogynecologists could be so dismissive to such vulnerable patients, many of whom were there after experiencing birth-related trauma. Support groups revealed my experience was not unique. I could only chalk it up to burnout and protecting their time; if a woman is distressed and they display empathy, it could invite further conversation. But is that all it takes to justify such poor bedside manner?

Perhaps the most disappointing part of my experience was the inconsistency in diagnosis, opinions about my extent of avulsion and whether or not they felt it mattered. Four of the five Urogynecologists waved their hands at any mention of avulsion and told me it makes no difference to their surgical approach, suggesting it doesn't matter. If research shows that avulsion is the biggest contributing factor in re-prolapsing/surgical failure, then why isn't it addressed and considered? After a 3D pelvic ultrasound with a fifth urogynecologist, they explained that due to my complete right avulsion, and partial left, my chances of prolapse recurrence after surgery sits somewhere between 60c70%. As there are currently no surgical options to repair avulsion, it wouldn't be statistically favourable to pursue surgery.

Not only was this news gutting, it reinforced my lack of trust in urogynecologists. Some said I had no avulsion despite being able to palpate it easily, others said unilateral or bilateral. After investing countless hours researching and thousands of dollars over the last two years, I've learned that statistically, the first prolapse surgery is the most successful and failure rates skyrocket for subsequent repairs. My priority is to find a Urogynecologist who agrees that 60-70% failure rates are not acceptable, particularly for young women in their thirties such as myself. I hope to find a Urogynecologist who sees beyond the pathological condition of prolapse and acknowledges the psychological and relational effects on their patients, keeping that understanding at the forefront of their interactions and the care they provide. I hope to find a Urogynecologist who has not become swallowed by burnout, rather rejects this broken, band-aid fix that has been offered to women as being the only solution and uses their education and experience to contribute to research, innovating and creating a long-term surgical solution for avulsion.

#### Lyn Leger

I found my urogynecologist through a referral from my women's health physiotherapist. During the physical examination by the physiotherapist, she identified likely avulsion of the levator ani muscle and explained that diagnosis was important for management and future treatment options. I



followed her advice and made an appointment with the urogynecologist for imaging.

Even before I arrived at the urogynecologist, I was struggling mentally and emotionally and could feel myself spiraling down into darkness. I did not know anyone with my injury, and my experience with some other medical and allied health providers at that point was that they didn't acknowledge or understand levator avulsion or how this impacted my life in so many ways (physically, being able to parent, my career, my sexual relationship, etc). I had two experiences with practitioners who told me, 'stop catastrophising' and 'this isn't terminal'. So I was feeling very anxious before my appointment.

On arrival and meeting the urogynecologist, I immediately felt at ease. She was welcoming, kind and empathetic, and asked me lots of questions about what had happened during the birth to cause the injury, what types of practitioners I had seen, what my understanding was so far of my injury and how I was managing to date. I was crying through much of this as it was extremely traumatic to relive and talk about. She listened and was genuine in all her responses. She explained everything to me, including the nature of the likely diagnosis, the statistics for the injury and prolapse, and various management options.

She then asked me if I was okay to have a physical examination, and when I said yes, she conducted the exam and imaging. Each step of the way, she stopped to explain to me what she was doing, what information this provided her and why it was important to her understanding of my injury. She showed me the images of the avulsion on the screen and pointed out that it showed full avulsion on the right and partial avulsion on the left. I was so devastated to see this on the screen, but at the same time, it was a relief to have someone so clearly show and explain to me what I had been experiencing.

She then sat me down and explained everything again based on confirmation of avulsion, and she demonstrated that she understood this was a lifechanging injury. She answered every single one of my questions, and she never made me feel stupid for asking questions, she took the time to make sure I was comfortable with every single answer she gave. Importantly, she understood that you can't ask questions about something you don't know anything about i.e. you don't know what you don't know. She gave relevant information without being asked. She took the time to explain in detail my management options and, due to my age, recommended 'conservative management' (pessary and physio). Based on all her explanations and information provided about the risks of each option, I was comfortable with her recommendations.

Following the appointment, she followed up with my GP to make sure she fully understood the diagnosis so that my Care Plan could be put together appropriately with the right allied health professionals involved.

I still see this urogynecologist annually for checkups and ongoing management. She is still just as kind and empathetic as at that first appointment. At each appointment, she gives information freely and updates me on the latest research around avulsion and possibly surgeries (which is sadly lacking). I strongly believe that if I didn't find this urogynecologist, who was kind and empathetic and took the time to explain everything in detail, I would not be here today.  $( \mathbf{ } )$ 

# **This POP life**

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Keshala De Silva RANZCOG Consumer Network Working Group member

Members of the general public, like myself, would rarely know about their pelvic floor, its function and role or how to recognise when it is stressed or injured. It took my Pelvic Organ Prolapse (POP) diagnosis to make me appreciate the amazing set of muscles that make up the pelvic floor. I wish I had known about them sooner.

Six years after giving birth for the first time, I found out I had torn my levator ani muscles, and the muscles in my pelvic floor were tight and weak from trying to keep everything together. It was my women's health physiotherapist who recommended that I see a gynaecologist to confirm what she suspected. The diagnosis came as a total surprise to me. It was even more of a shock to find out that I had possibly torn these muscles during childbirth when I had a vacuum assisted delivery. Even with an amazing delivery team, I felt let down and was disappointed that there were no questions or follow-up care related to the pelvic floor during my second pregnancy and delivery.

For many people who are diagnosed and living with POP, it is life altering! Once you are diagnosed with POP you are bombarded with information and comments on what to do, and what you can't do. It is confusing, isolating and has a huge impact on mental health.

Those first three years after my diagnosis, it felt like there were a million restrictions on living life, as it could worsen my POP. Initially, I found it hard to find information and easily swap/modify daily routines and tasks. A daily routine like picking up the kids, groceries and washing the dishes, now required extra mental load to maintain posture, breathe and relax pelvic muscles. The good news is that over time, this did get easier and more habitual; it just took a long time. The road to regaining a functional pelvic floor can be long and requires more than just a doctor or a gynaecologist to be supported in this journey. The challenges and barriers to finding help are immense and the differences in the resources and support available vary between State, Country and insurance coverage. In Australia and New Zealand, some of the challenges are the cost (including travel and/or babysitting) and time to attend appointments and finding someone with the relevant expertise locally or online.

Due to the many hurdles and the messaging out there, many with POP learn to bear with the pain and discomfort. However, this is changing, partially due to social media, as women can connect with others who are on a similar journey. It also provides the opportunity to connect with health professionals that have strong online presences. I have been a part of many wonderful online support groups that have developed their own set of amazing tools and resources to help their community live a happier life with POP. It is through these groups and by following experts that I felt empowered to piece together my own plan and seek help to strengthen my pelvic floor.

I am very aware that I am privileged. Much of the information about the pelvic floor is in English, I lived in an urban area, had access to a car, internet, a phone, an income, support to look after the kids when I went to appointments and knew/ felt safe enough to look for support online. I got into advocacy because I think people with POP, regardless of gender and age, should have access to the same care and resources that I did, and we all should have some awareness of our pelvic floor.

Women's health physiotherapists are a key part of POP management, and one of many health professionals that a woman will need to see to understand their pelvic floor and management plan. It was great to hear that a hospital in Christchurch, New Zealand had increased the number of women's health physiotherapists in their department. These physiotherapists triaged and provided ongoing support for the women who attend the clinic. In doing so, the gynaecology team were able to see more women and reduce the referral waiting times, without reducing the care outcomes.

At present, 1 in 2 women who have given birth and 1 in 3 female athletes, will experience POP. Simply being female is one of the risk factors of developing POP. I often wonder what the statistics would look like if we were more educated and aware of the pelvic floor from a young age. POP can happen to anyone, it just happens to women more than men and children.

The risk factors for pelvic floor dysfunction are often not discussed in a doctor's office. An example is a woman presenting with chronic IBS or constipation will have a treatment plan focused on managing

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symptoms and the condition; however, the impact it may have on the pelvic floor is not often discussed and so, the patient may not be aware of some of the long-term consequences.

Childbirth related pelvic floor injury and POP may not be preventable for everyone, but it certainly helps to know of the risks and preventative measures that can be taken to reduce the severity and frequency of POP. I strongly believe that pelvic health and awareness needs to be a part of the physical education curriculum and sports programs, to empower people to advocate for themselves. Another factor that would help people is, promoting self-checks and encouraging pelvic awareness, to be able to identify normal and abnormal pelvic floor muscle behaviour. Knowing your baseline muscle behaviour can inform management plans and ability to advocate for appropriate care. As the pelvic floor is hard to see, unlike a bicep or calf, many people aren't aware of it being stressed or injured. Pelvic floor function and health is just like any muscle in our body, it needs to be taken care of. We all have a pelvic floor, just some of us are more at risk of POP than others. This pelvic awareness month, I am looking forward to hearing and talking to people about the pelvic floor.



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# Physiotherapy after mesh complications

Managing the complex pelvic pain patient



Sue Croft OAM Physiotherapist Author Pelvic Floor Recovery: Physiotherapy for Gynaecological Repair Surgery and Pelvic Floor Essentials

Complications associated with mesh include exposure and erosion of the vaginal wall,<sup>1</sup> bladder and urinary tract injuries,<sup>2</sup> urinary retention,<sup>3</sup> nerve damage and persistent pelvic pain (PPP)<sup>2,4</sup> including dyspareunia, and can lead to significant mental health issues for the woman and damaging relationship breakdowns.<sup>5</sup> There have been severe depressive symptoms due to the ongoing distress caused by mesh complications including death by suicide.<sup>5,6</sup> The physical, mental and financial cost to women due to unsuccessful mesh implantation has been huge.

Evidence tells us that PPP is more effectively treated when a biopsychosocial approach to pain is undertaken.<sup>7</sup> Pelvic health physiotherapists in Australia use this best-practice approach in their management plan for PPP by adapting the model extensively researched and taught by Australian physiotherapists and pain researchers, Prof Lorimer Moseley and Dr David Butler.

A biopsychosocial approach includes understanding about the interplay between the biological, psychological and social aspects of the patient's condition. Understanding the influence of other factors is important for all health professionals involved with mesh patients in order to effectively treat their PPP.

Many women feel injustice with their mesh implant complications. This is due to the initial silence surrounding the issue, the extent of the problem and the ongoing use of mesh for many years despite the compelling evidence to the contrary. The women in the mesh class action legal case in Australia are also facing the distress of reduced compensation payouts due to the large costs subtracted by the legal team who were instrumental in bringing the dreadful stories of these women into mainstream media.<sup>8</sup> Factors such as injustice can be measured via the Injustice Experience Questionnaire.<sup>9</sup> This has a scoring range between 0–52 (subscales Blame/ Unfairness and Severity/Irreparability) with a score of greater than 30 representing a severe risk of ongoing disability at one year. The injustice suffered by these women has an impact on the severity of their pain. The full recovery of the patient will be stifled if this is not recognised and addressed as a part of the treatment of the patient.

Anger and rumination add to the psychological burden for women who have mesh injuries. The Pain Catastrophisation Scale is a measure of painrelated thoughts and beliefs, measuring rumination, magnification and helplessness. However, currently there are no validated measures that are specifically designed to assess pain associated with pelvic mesh implants. More research is required considering the burden that women have suffered with this catastrophic failure of the healthcare system.<sup>10</sup>

Social influences such as family, friends and work colleagues and their ability to maintain a relationship with a woman in constant pain are also factors in pain amplification. Health professionals being curious about these impacts rather than dismissive will help with understanding the complexity of a women with persistent pain from failed and problematic mesh implantation.



'Woman in Pain' by Katie Martel 2002

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There is little doubt that the significant complications associated with mesh implantation (such as mesh extrusion and severe pelvic pain) increase anxiety in women.<sup>5</sup> Anxiety is associated with adrenaline and cortisol release which can amplify pain. Thoughts are chemical processes and may provoke inflammatory responses in the relevant tissues. Over the years women have formed support groups on Facebook which can be seen both as a 'saviour' and 'escalator' of their anxiety. When women finally realise the extent of the mesh problems and the number of women affected, they feel validated, and this can be helpful for them. However, hearing the terrible stories of suffering within a group can also be triggering for many women. This contributes to anxiety about their condition, catastrophising, heightened central sensitisation of their nervous system and ultimately may worsen their pain.

The patient's inability to work because of persistent pain adds to financial distress and heightens anxiety. Some patients incur high medical expenses undergoing the necessary treatment by health professionals for their mesh complications if they are unable to source treatment in publicly funded pelvic mesh centres, adding to their financial hardship.

Physiotherapy assessment of the patient with PPP involves listening to their story. This provides validation to the patient that the therapist before them understands how important their story is to the fabric of their treatment plan and creates a therapeutic alliance with the patient. Baroness Cumberlege in her 2020 UK report on Medical Devices Safety Review 'First Do No Harm' said that 'the system is not good enough at spotting trends in practice and outcomes that give rise to safety concerns. Listening to patients is pivotal to that'.<sup>11</sup>

Assessing the patient's urinary system function (with a bladder diary, a pre and post void ultrasound and noting any history of any urinary frequency, recurrent UTI's, urgency and urinary leakage), bowel function (including regularity, stool consistency, any associated pain and faecal control); sexual dysfunction (pain with sex, fear avoidance of intimacy, loss of sensation and complex feelings of loss of being a 'broken' woman associated with their predicament); pelvic nerve pain and referred pain; pelvic floor muscle activity (or overactivity); and their tissue quality, guides treatment strategy selection.

Asking the patient about their goals and expectations from their physiotherapy interaction ensures that the therapist is addressing the patient's concerns rather than the therapist's preconceived ideas about what they believe to be important.

Education is the cornerstone of any pelvic health physiotherapy treatment. Teaching bladder voiding position, efficient pain-free bowel emptying, and good bladder and bowel habits is important to address the biological problems associated with mesh implantation complications.

Bladder residuals leading to chronic urinary tract infections; urinary leakage due to failed effectiveness of sling procedures; overactive bladder leakage; or removal of the offending sling or vaginal mesh leading to the reinstatement of the pre-existing stress urinary incontinence or prolapse are all distressing problems well-served by the conservative strategies taught by pelvic health physiotherapists.



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Taken from 'Pelvic Floor Essentials' by Sue Croft 2022

The pelvic floor muscles are often overactive with the patient increasing the muscle tone inadvertently by over-clenching in response to pain, to leakage of urine or faeces or to stress and anxiety. Van der Velde 2001 showed that the pelvic floor muscles behave as 'first responders' in response to stress and anxiety, reinforcing the concept that the pelvic floor muscles are hardwired to protect.<sup>12</sup> Other muscles in the pelvis can also be implicated. Referral patterns of tension from obturator internus can be seen with other presenting conditions such as coccydynia, Piriformis Syndrome, low back pain and sacro-iliac joint pain among others.

Teaching patients:

- Regular daily pelvic floor muscle down-training.
- Pelvic nerve and pelvic muscle stretches.
- The value of regular belly breathing to enhance the parasympathetic nervous system response over the fight-and-flight sympathetic nervous system upregulation.
- Body scanning to assess muscle tightness and subsequently relaxing the overactive muscles.
- Changing posture into a more slumped and relaxed posture to facilitate abdominal and pelvic muscle relaxation.

These are all invaluable, easy-to-implement treatment strategies which give self-efficacy, and empower the patient to self-manage their pelvic pain more effortlessly.

Woven into the effective treatment of these biological factors is the important concept of teaching effective pain science to the patient. Understanding the concept of central sensitisation is pivotal to explaining how persistent pain upregulates. This involves teaching the concept that pain is not always solely about the issues in the tissues.



Measuring the degree of central sensitisation through the validated Central Sensitization Inventory: Part A and Part B (CSI) gives the physiotherapist and the patient insight into the extent of the persistent pain and allows measurement of the progress of the patient with their pain management (if the questionnaire is used regularly).<sup>13</sup>

Treatment of the sensitised nervous system includes graded exposure to the perceived threat which allows for reorganisation of the sensori-motor cortex through novel non-threatening stimuli and movement. For example, if dyspareunia is an ongoing problem following mesh removal, the pelvic health physiotherapist will teach the patient how to use vaginal trainers (dilators) to allow graded exposure to penetration. The patient will be taught



Femmax Dilators (these can be purchased from PelvicFloorExercise.com.au)

the importance of good arousal, good tissue quality (from local oestrogen if age appropriate) and the use of an effective lubricant to achieve pleasurable, painfree intimacy.

Health professionals working with patients with persistent pain from mesh implantation must be conscious of the importance of the language and words used. This is fundamental to maintaining a good therapeutic alliance with the patient. Encouraging the patient to be kinder to themselves when they may have a sense of hopelessness from years of persistent pelvic pain is also important when treating pain.

Understanding pain science empowers the patient to have greater autonomy over their treatment process which ultimately helps their financial situation. If the concept of central sensitisation is well explained, it makes complete sense to the patient and can often lead to a faster decrease in pain and symptom resolution increasing the credibility of the physiotherapist. This allows the physiotherapist to assist the patient to change the narrative of their pain story without ever disputing or diminishing the importance of the biological factors at play.

Physiotherapy treatment of PPP associated with mesh implantation decreases catastrophising, empowers women with self-management strategies to treat their pelvic health issues throughout their life and explains why their symptoms can flare unexpectedly despite long periods of improvement with their condition, allowing them to self-manage the flare and return to a high-quality lived experience.

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JROGYNAECOLOGY

# Urogynaecology in developing countries



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Prof Ajay Rane OAM, PSM Urogynaecologist

While the developing world continues to optimise progressive patient outcomes, the majority of urogynaecological patients around the world are battling more rudimentary targets. A resounding disparity in healthcare literacy and the availability of medical services means that largely preventable pathology remains a significant cause of urogynaecological morbidity in under resourced settings. This paper will look at several aspects of urogynaecological healthcare from a global perspective, what can (and should be) done about it and what we think the future holds.

The most well-known urogynaecological issue on a global-health scale is that of female genital fistulae. The World Health Organization (WHO) estimates that two million women worldwide suffer from untreated genital fistulae and 100,000 new cases occur annually.<sup>1</sup> The majority of these cases occur in the context of obstructed labour, which causes ischaemia and eventual necrosis of pelvic organs, leading to fistula formation between two epithelial surfaces. Obstetric fistulae effect the poorest, most disadvantaged women. The advent of a fistula in the absence of specialised medical care can be the start of morbid slippery slope of repercussions. In addition to the well-known symptoms of incontinence of urine and/or faeces. pain and dyspareunia, women experience social marginalisation and financial boycotting

From an urogynaecological perspective. reconstructive pelvic surgery following genital fistula formation remains an incredibly complex aspect of clinical practice. Although the post-operative success rates of genital fistulae repairs can be high<sup>2</sup> optimal outcomes require a highly refined surgical skill set in specialised centres. A primary prognostic factor in reconstructive surgeries for genital fistulae is the degree of fibrosis.<sup>2</sup> The longer patients wait to present for care, the greater the degree of scarring and this makes the tissue friable and more likely to dehisce post operatively. Unfortunately, due to the taboo nature of the injury, fear of further marginalisation, vulnerability of patients and a lack of access to medical facilities, patients often time delay presentation. This complex interplay of intricate pelvic pathology occurring in significantly under resourced settings with profound social stigma both exacerbates and prolongs the plight of women with genital fistulae.

Another aspect to the cycle of genital fistulae is sexual violence to the pelvic floor. The WHO estimates that 1 out of 3 women will experience sexual or physical violence in their lifetime.<sup>3</sup> The most common form of sexual violence is forced penetration with male genitalia but sharp objects. chemicals and even firearms are used. Perpetrators of sexual violence can often be well known to the woman, with the act being conducted in familiar settings like schools, healthcare facilities or as part of a cultural initiation. Unfortunately, sexual violence tends to be exacerbated during times of conflict and even employed as a weapon of war. An alarming trend over the past decade has been the increase in the rape of girls under the age of ten, which has increased from 3% to 6% of all treated cases at some centres.<sup>4</sup> As expected, following sexual violence, the delay in presentation for medical care is usually further drawn out. In addition to the surgical complexities that these vulnerable women pose, they require a more holistic approach to care from a rehabilitation, social and psychological point of view.

As parts of the developing world start to prosper from an economic and social point of view, the urogynaecological challenges faced locally likewise alter. In our recent trip to Bangladesh, the rise of a more educated and financially stable middle class has meant that health literacy has increased. Thus, presenting complaints of prolapse symptoms or urinary incontinence, which were previously perceived as negligible start to come to the forefront. Thus, local surgeons are faced with a patient demand that they may be uncomfortable dealing with from a surgical skillset point of view. In addition to this, an increased knowledge of available management options (by clinicians and patients alike) leaves a void in treatment options if those services are not available. While the use of laparoscopy by gynaecologists in the developing world remains in its infancy, this comes with its own set of issues. There has been a rise in iatrogenic female genital fistulae which are usually higher in the pelvis (involving ureters) and can be more difficult to manage. In



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some centres, iatrogenic fistulae are now starting to account for nearly 40% of all cases.<sup>5</sup>

While the global picture of urogynaecology may seem like a story of resounding doom and gloom, there are certainly positive facets looking to the future. While a solid legal framework is part of the picture, the issue extends much deeper and needs to be addressed at its core. Predominantly, this comes down to empowering women towards primary prevention. A change of culture can be instigated through increased access for women to education and healthcare. As a team we have successfully undertaken urogynaecology capacity building over the last two decades in the Pacific and Sub-Continent. Our model is to teach and mentor local doctors in pelvic anatomy, patient assessment (and selection), surgical management and follow up. To date we have managed to mentor 42 consultants in the Pacific through regular visits and close follow up of surgical outcomes. These gynaecologists have then gone on to practice in some of the most remote places on Earth (like Kiribati and Tuvalu). We have managed to liaise with local teams and form specialised centres that aim to provide holistic urogynaecology care. We provide lectures to doctors (from residents to consultants) as well as midwives and physiotherapists. Over time, this has led to the development of proficient urogynaecological teams, who can appropriately assess patients, safely operate while knowing their limitations, manage complications and follow up patients. In addition to this, we provide surgical equipment and follow-up channels for the pre-operative multi-disciplinary discussion of difficult cases. This has been achieved with simple WhatsApp groups where cases are discussed and combined opinions formulated towards optimising patient care.

As a further means of secondary prevention, the Federation of International Gynaecologists and Obstetricians (FIGO) fistula surgery training initiative has made great inroads towards the WHO goal of eradicating obstetrics fistulae by 2030. FIGO developed a structured curriculum for the training of fistula surgeons. The program thus far has facilitated for the administration of appropriate equipment, facilities and trained personnel to some of the most vulnerable women on earth. This initiative has provided life-restoring treatment and dignity to over 6000 women thus far.<sup>6</sup> Since this article has been published, that number has now reached a staggering 18,000 women.

The final step towards addressing this inequality of urogynaecological care across the globe, as with any interventional measure, is raising awareness. The disempowerment of women remains a contentious and somewhat taboo topic despite it affecting millions of vulnerable women worldwide. Through a sustained effort of highlighting inequalities and the promotion of safe interventional holistic care, things can (and will) slowly but surely change.

If you would like to get involved or donate towards our efforts, please visit https://flourishingwomen. com.au/

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# Female genital tract fistula



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Female genital tract fistulas are not uncommon in limited resourced areas, in particular, where the provision of emergency obstetric services is under resourced. The Ethiopian<sup>1</sup> and Ugandan<sup>2</sup> demographic and health surveys states that the percentage of women 15-49 years of age, who experience fistula symptoms are 0.4% and 1.4% respectively. Over 15,500 women in Ethiopia and 18,500 Ugandan women in this age group experience leakage of urine and/or faeces through the vagina. Women with obstetric fistulas suffer from significant mental health and social dysfunction<sup>3,4</sup> and ongoing bladder dysfunction.<sup>5,6</sup> In Australia, lower urinary tract fistulas (urethro/vesico-vaginal) are often related to gynaecological procedures7 and ano/ rectovaginal fistulas are often due to obstetric and operative aetiologies.8

#### Lower urinary tract fistulas

In the review of 56 lower urinary tract fistulas repaired by two experienced fistula surgeons (Hannah Krause, Judith Goh) following benign causes/procedures,<sup>7</sup> the most common antecedent events were hysterectomy, urinary incontinence and urethral surgeries and also procedures that may not be considered as associated with fistulas, including suction curettage and cervical cerclage. Although all women presented to the original surgeon with continuous urinary incontinence, only 50% of women were referred by the original surgeon for management of urinary incontinence. Of the 56 women with fistula, two thirds were referred with a



diagnosis of fistula and the remaining referred for management of urinary incontinence. In addition, 15 of the 56 women had a recognised intra-operative cystotomy repaired at time of surgery. However, despite this history, the time of original surgery to referral for management was about three months. The mean time from antecedent surgery to referral for management of fistula or urinary incontinence was nearly five months.

Imaging on these 56 women<sup>7</sup> demonstrated 42% positive results from CT cystourethrogram and CT intravenous pyelogram in diagnosing the fistula while cystoscopy had similar results with a 43% positive rate. The dye test was most sensitive in diagnosing the lower urinary tract fistula (Figure 1). The fistula size ranged from 2mm to 4cm (mean 9.75mm) with no clear relationship between size of fistula and positive results from investigations.



Figure 1: Positive methylene blue dye test from a vesico-vaginal fistula

All 56 women underwent the vaginal approach for fistula closure via the flap-splitting technique. Fifty-five women had successful closure of the fistula with the first surgery and the remainder, with a late breakdown three months later, required a second repair, which was successful.<sup>1</sup>

Over the past two years, the author has repaired another 14 lower genital tract fistulas in Queensland, again hysterectomy being the most common factor. There were also two vesicovaginal fistulas from neglected prolapse pessaries (size of fistula 1cm, 3cm).

#### **Anorectovaginal fistula**

Women with anorectal fistulas complain of flatus, mucous and faeces per vagina. For the smaller fistulas, faecal material often passes per vagina

when the stools are not well formed. World-wide. obstetric related fistulas are most common. While there are true obstetric rectovaginal fistulas, many women present to fistula units/campaigns with faecal incontinence from chronic unrepaired 4th degree tears.<sup>9</sup> (Figure 2)

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Figure 2: Unrepaired 4th degree tear - note absent perineal body

A review of 41 women who were referred for anorectovaginal fistula management in SE Queensland demonstrated that apart from obstetric and gynaecological aetiologies (including prolapse pessaries), infective and inflammatory conditions play a role in our setting.<sup>8</sup> Perianal abscesses might mimic the appearance of a Bartholin's abscess and incision and drainage in the vagina/labia may inadvertently complete the connection between the anorectum and vagina/perineum, causing a fistula. In five of the 41 cases, these women cited marsupialisation of a Bartholin's abscess as the procedure related to fistula formation. In this review of the 41 women, faecal diversion did not improve surgical outcomes.8 The average size of the fistula was 11.2mm in diameter (range 2-50mm)

For closure of anorectal fistulas from infective or inflammatory bowel disease, it is recommended that the infection/inflammation is treated in the first instance. It is also generally believed that there is a higher risk of fistula breakdown when the fistula is due to an inflammatory process e.g., Crohn's disease, and also risk of further fistulas with flare ups of the inflammatory bowel disease even after successful fistula closure.

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Full reference list available online

#### Principles of surgical management of genital tract fistula

The route of repair of lower genital tract fistulas is dependent on surgeon experience and preference

#### Recent urethral/bladder injury with fistula

- catheterisation (4 weeks) If the fistula is established with fusion of

#### No inflammation present

#### Small fistulas – dye test may help locate the fistula in the vagina (Figure 1)

#### Wide mobilisation of vagina from affected

- structure (urethra/bladder or ano/rectum)
- The author does not excise any vaginal epithelium as this may cause vaginal stenosis
- Unless the fistula is located at the perineal body, there is NO 'fistula tract'

13/06/2023 6:00:00 PM

- Test integrity of the fistula repair

  The author uses methylene blue for lower

#### Close the vaginal epithelium

#### Prolonged indwelling catheter for lower urinary tract fistulas

woman's upper thigh) to avoid pulling/tension on the bladder

#### Antibiotics

just prior to catheter removal to ensure the fistula is closed, followed by an immediate trial of void.

# What's new in urogynaecology?

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Research and innovation in women's health is shifting towards more patient-centred, personalised, and translational approaches. This change is particularly evident in the field of female pelvic floor dysfunction (PFD). Obstetricians, gynaecologists, urogynaecologists, urologists, basic scientists, and general practitioners with an interest in O&G need to adapt to this paradigm shift. Researchers need to keep up with these emerging trends and newer directions to improve patient care.

#### **Patient-reported outcomes**

Patient-reported outcomes (PROMs) have become an important focus in healthcare research and treatment in recent years. Functional outcomes, such as sexual function and quality of life, are particularly relevant to patients and are often listed as their primary treatment goals. PROMs can provide valuable insights into patients' experiences and treatment outcomes. which can help to inform clinical decision making and improve patient satisfaction. Various measures are available to assess PROMs in both research and clinical settings, including IMPACT<sup>1</sup> and PROMIS<sup>2</sup> for pelvic floor complaints and the OAB-Bladder Assessment Tool for overactive bladder symptoms.<sup>3</sup> Telemedicine has emerged as a viable solution for many medical situations, including urogynecology and female urology, particularly in light of the COVID-19 pandemic.4

#### **Non-surgical management of PFD**

Pelvic floor muscle training (PFMT) has been shown to be an effective treatment for stress urinary incontinence (SUI) and other urinary conditions in women.<sup>5</sup> Electrical stimulation can be combined with PFMT to enhance its effectiveness.<sup>6</sup> Non-surgical treatments such as yoga,<sup>7</sup> transcutaneous electrical nerve stimulation,<sup>8</sup> and acupuncture<sup>9</sup> have also shown promise in managing lower urinary tract symptoms. Sacral neuromodulation<sup>10</sup> is a safe and effective therapy for urinary incontinence but may



not be accessible to all due to expertise and funding limitations. Contrary to traditional approach, there is strong evidence that Botulinum toxin (BoNT-A) injections for overactive bladder have been found to be more effective when injected into the trigone area rather than in a 'trigone-sparing', particularly for neurogenic detrusor overactivity.<sup>11</sup>

#### **Novel therapy**

Stem cell therapy has shown promise for treating bladder dysfunction, but it is not yet available for clinical use.<sup>12</sup> Clinical studies of stem cell therapy for pelvic floor disorders have produced mixed results, and more research is needed to compare the efficacy of stem cell therapy to existing treatments. In a systematic review published in 2021,13 A total of 11 prospective clinical studies were included in the final assessment, specifically seven single-arm studies dealing with SC therapy for stress urinary incontinence and four with anal incontinence. No papers concerning the use of SC for prolapse repair were retrieved. Due to the great heterogeneity, data pooling was not possible. A clear beneficial impact of SC treatment for the treatment of pelvic floor disorders could not be demonstrated. A recent study found that single-incision mini-slings were as effective as standard midurethral slings for treating stress urinary incontinence, with similar rates of complications over a 36-month follow-up period (SIMS study).<sup>14</sup>. Robotic surgery has also gained popularity for pelvic floor reconstruction, and a group of experts concluded that robotics is a suitable indication for pelvic floor reconstructive surgery. A meta-analysis and systematic review of 49 studies found that robotic-assisted surgery may have some advantages over conventional laparoscopic surgery, but high-guality, large-sample randomised trials are needed to compare the two techniques.<sup>15,16</sup>

#### **Vaginal mesh**

Vaginal mesh removal for pain or exposure continues to be problematic. A recent study found that after complete vaginal mesh excision, only 33.3% of women with pain alone reported improved symptoms compared to 73.9% with exposure and 58.3% with exposure plus pain.<sup>17</sup> Basic science research is needed to rectify the product development strategies of the past that led to the mesh debacle as discussed below.<sup>18-20</sup>

#### **Basic science innovation**

There is enormous basic science interest in PFD. For instance, one recent interesting insight is that in the bladder microbiome, higher bacterial diversity in the absence of Lactobacillus dominance has been found to be associated with urgency UI and resistance to anticholinergic treatment for this condition.<sup>21</sup> Three-dimensional (3D) printing has shown promise in the field of urogynecology, with a pilot study demonstrating that tailor-made pessaries created using transvaginal ultrasound and 3D printing technology may offer better solutions for women with pelvic organ prolapse (POP).<sup>22</sup> Additionally,

a proof-of-concept study has demonstrated the potential of using fused deposition modelling (FDM) and 3D printing (thermoplastic polyurethane (TPU) meshes that eluted  $17-\beta$ -oestradiol (E2) were produced by fused deposition modelling (FDM) to investigate a new generation of safer mesh implants for POP treatment with fracture force testing showing these meshes appearing to be more elastic.23 Current clinical meshes trigger unfavourable foreign body responses, which lead to graft failure in the long term, so researchers are investing in a variety of emerging technologies such as electrospinning and 3D printing to design new meshes. Researchers are also exploring cell-based tissue engineering strategies to augment the new class of meshes to improve biocompatibility and immunomodulation.24

#### **Cross-disciplinary interrogations**

Functional neuroimaging has been used to investigate central lower urinary tract (LUT) control and the coordination between pelvic floor muscle contraction (PFMC) and micturition. In a systematic review, core brain areas of LUT motor control were determined, and it was found that the involved brain areas for PFMC and micturition are partially distinct.<sup>25</sup> This opens the gates to better understand the pathophysiology of prevalent diseases within functional female urology, such as overactive and underactive bladder (OAB/UAB), bladder pain syndrome (BPS), and dysfunctional voiding. Precision medicine is increasingly being applied in the field of urogynecology. In a study by Orlicky et al,<sup>26</sup> a Pelvic Organ Prolapse Histologic Quantification (POP-HQ) system was developed to systematically evaluate the cervical portion of the uterosacral ligament in women with POP. Three distinct histologic phenotypes were identified in the POP group with varying overlap with the control specimens: POP-V, dominated by vascular alterations; POP-A, characterised by the preponderance of adipose infiltration; and POP-I, with the prevailing increase in inflammatory neutrophils. The authors used these to further hypothesise how they developed in the subset leading to POP. The major goal of quantitative phenotyping is to enable rigorous genotypephenotype correlations and the development of reliable biomarkers to predict POP progression and an individual patient's therapeutic response, neither of which is currently possible.

### Artificial intelligence (AI) and decision support systems

Like every other field of life, this has arrived, whether or not health professionals feel prepared to embrace it. These systems use big data, including PROMs, to develop algorithms and diagnostics that can improve healthcare. However, the quality of the output is only as good as the input, and poorly labelled data can lead to inaccurate results. This in engineering language is the GIGO paradigm: 'Garbage in-Garbage out'! The development of accurate and reliable decision support systems is essential in providing patient-centred solutions tailored to each woman's characteristics, symptomatology, and expected goals for outcomes.<sup>27</sup> Moosavi et al<sup>28</sup> utilised 12 risk factors to accurately predict de novo SUI such that the accuracy of this model was more than 90%, compared favourably to other conventional state-of art SUI risk prediction models.

#### Societal and population-related aspects

Research is ongoing into the relationship between caesarean birth rates and pelvic floor dysfunction

rates in the population. Caesarean birth can reduce the risk of PFD in some women.<sup>29</sup> However, it can also increase the risk of other complications such as surgical site infections, bleeding, and longer hospital stays. More research is needed to fully understand the impact of increasing caesarean section rates on PFD, considering factors such as maternal age, parity, and the reason for the caesarean section.

Numerous studies have investigated the influence of health disparities among women with pelvic floor disorders, with varied results. Racial/ethnic disparities and inadequate ethnic labelling inconsistently indicate differences in prevalence of disease, disease severity, and treatment outcomes. For instance, future studies should differentiate and subclassify Hispanic and Asian ethnicity<sup>30</sup> and incorporate strategies to address barriers for clinical trial enrolment of racial and ethnic minorities. Diversity in research leads to improved understanding, which leads to improved patient care for all.

#### Conclusion

There is increasing focus on personalised medicine and translational and interdisciplinary approach to cutting-edge research in the field of urogynaecology. Shared decision-making in the current setting implies the practitioners be aware and agile to these so that they can provide their clients with best possible and evidence-based care.

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# Rebuilding urogynaecology

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It isn't easy practicing urogynaecology these days. None of us entered the practice to cause harm. We understood and regretted transvaginal mesh for primary prolapse. It was not that helpful and potentially harmful, and more importantly, very difficult to remove. However, for stress urinary incontinence (SUI) we have been offering midurethral slings (MUS) since 1998 and we were accustomed to women thanking us for changing their lives and wishing they had had the procedure sooner. After 10 years doing the procedure, we might have come across a patient with severe pelvic or vaginal pain and dyspareunia. Yet the procedure on that patient was no different to the many other cases we performed. That patient weighed heavily on our psyche but did not lead us to feel we should stop offering MUSs as a treatment option. What about all the people that benefitted from the procedure?

Now 20 years later, after the Senate Inquiry of 2018 and the Gill v Ethicon Class Action of 2019, many of our colleagues have stopped operating on women with incontinence for fear of litigation. The remainder of us have widened our skillsets to include treatment options beyond MUSs. Some of us adopted bulking agents, with their variable results (and the women weren't thanking us as much). Others with a laparoscopic skillset were offering laparoscopic burch colposuspensions. Those without laparoscopic skills moved to open surgery, such as fascial slings.

What has followed has been a decline in the number of incontinence procedures. In 2011 there were 7081 continence procedures of any kind performed for stress urinary incontinence in Australia according to the Services Australia Website. By 2022 this number had decreased to 2917 (Table 1). This raises some important and interesting questions. Were women in 2011 being overtreated for mild stress incontinence because MUS was viewed by both surgeons and women as simple minimally invasive low risk procedure. Or are too many women unnecessarily incontinent in 2022 because they or their clinicians are fearful of surgery? I suspect both statements are true.

Back in 1998, when MUS surgery was first emerging as a surgical option in Australia, more than 4800 women had continence surgery, primarily open colposuspensions. This number may be higher if anterior vaginal repairs (with Kelly sutures) are considered, given that this procedure was commonly performed for SUI at the time. For women to decide to undergo a more invasive procedure it is likely that they had more than just mild SUI and were suffering significantly with moderate to severe SUI. Therefore, since 1900 fewer women had SUI surgery in 2022 than in 1998, I suspect there is a sizeable number of women suffering with significant untreated SUI in the community at the moment.

Perhaps women are no longer seeking treatment. Perhaps women have stopped visiting surgeons to manage their stress incontinence in favour of other non-surgical professional groups instead. It is difficult to know for sure because of the lack of formal data on this. I suspect more women are seeking conservative management and accessing pelvic floor muscle training, vaginal devices, extracorporeal magnetic innervation (Emsella chairs) and vaginal laser. To what degree women undertaking such treatments are helped or satisfied with these treatments is unknown.

It is a concern to think that several thousand women every year are remaining incontinent and avoiding surgery because of the fear of mesh, and loss of trust in us as surgeons. We have become tarnished by association with the negative image that mesh now has. The simple logic is, if mesh is bad, and surgeons promote mesh, then surgeons must be bad. We can only help women with pelvic floor problems if we ensure our practice is of a high standard and worthy of the public's trust in us and our profession.

Surgeons have a responsibility to make women aware of the range of approaches that can be offered to manage their incontinence, including pelvic floor muscle training, intravaginal devices such as continence dishes and contiform devices, as well as surgical approaches. When a surgical approach is discussed, women should be given the ACSQHC information sheet, and summary data comparing surgical procedures. They should be given the chance to read these and other resources in their own time and return for a subsequent consultation to have their questions answered and be allowed to choose the procedure they want. If their preference is for a procedure that their surgeon is not trained to perform, that surgeon should refer the woman to a colleague that can perform that procedure. In the meantime, such surgeons need to



Year	Midurethral Sling	Colposuspension (open or laparoscopic)	Autologous Fascial Sling	Transurethral Bulking Agent	Total
1998	725	2887	743	446	4801
2011	5878	322	363	518	7081
2022	1156	332	312	1117	2917

\*data from Medical Services Australia

expand their skillset to encompass other minimally invasive procedures such as laparoscopic burch colposuspension, and begin teaching their trainees. In this way, one woman at a time, we might help restore women's confidence in us, and be an ongoing help with their continence issues.

Mesh sacrocolpopexy (Mesh SCP) has been the goldstandard procedure for apical pelvic organ prolapse since the operation was first described in 1957. It was not mentioned in the Senate Inquiry, it is reserved for women with the most severe prolapse. Yet access to mesh for such women is being compromised. The absence of mesh as an option for such women would put them at higher risk of suboptimal outcomes.

In 2019 (before Covid) there were 824 cases performed in Australia compared to over 16,000 vaginal prolapse cases. The lack of access to mesh could not have come at a worse time. By 2022 the cases of sacrocolpopexy had decreased to 598. Surgeons have been forced to perform colpocleisis procedures in women who otherwise might have wanted to retain sexual function. These colpocleisis procedures increased from 127 women in 2019 to 218 cases in 2022 (Services Australia Website). Some surgeons are using fascia lata or cadaveric material, though such products may not be as robust as mesh and carry morbidity from leg incisions.

The problems with mesh access for sacrocolpopexy have been even more complex than for MUS. To summarise, the TGA upgraded the classification of meshes from class II to class III in 2018. International companies such as Coloplast, Boston Scientific, and Ethicon, were therefore required to provide further data, at a greater cost, to justify keeping their meshes on the theatre shelves for this procedure. All companies withdrew their products leaving none available for women needing sacrocolpopexy. At the time of the TGA request, no other country had asked such companies to justify their products, but many of these companies are now having to make similar efforts to keep their products in Europe and hopefully might rethink their decision to abandon Australia in the future.

Because of the actions of the TGA and mesh companies, there is currently no Class III mesh available on the shelf for women needing sacrocolpopexy in either Australia or New Zealand. This is a desperate situation considering this procedure is treating the women with the worst prolapse. Even the UK (which has paused MUS) still has access to these products. Only one product designed and marketed for sacrocolpopexy is available, but this is not on the Register of Therapeutic Goods and is available only via the Special Access Scheme. The situation is worse in New Zealand where there is no Special Access Scheme product available. In Australia, the product TiLOOP (pfm GmBH) is attempting to achieve Class III status, but is awaiting European CE approval outcomes before applying to the TGA. If successful, it will be the only sacrocolpopexy-specific product available to women.

One other reason for the lack of access to mesh (and hence the decline in SCP cases), at least in the private sector, is resistance from health insurance providers. In the private sector, surgeons are receiving SAS approvals for TiLOOP, but insurance companies are refusing to pay for the product because it is not on the Register of Therapeutic Goods. It is theoretically possible that some surgeons in the private sector are using generic class III hernia mesh off the shelf and off label for the sake of their patient, but at their own risk. Calls from the TGA to insurance companies have fallen on deaf ears.

Another reason for the decline in SCP cases is fear of mesh by women and their families. A patient I recently saw had recurrent apical prolapse seven years after I had performed a vaginal hysterectomy and sacrospinous fixation. On examination she had a narrow vagina not amenable to vaginal devices or repeat vaginal surgery or colpocleisis. I offered a laparoscopic mesh sacrolpopexy. I did not think fascia lata would do an adequate job in her case as it would only support the anterior compartment; however, I did not offer this as an option. I described the mesh procedure and went through a dedicated consent document with her word for word. She took the idea home to her family who immediately banned her from proceeding without wanting to discuss this further. The family decided that mesh is bad, and that since I offered it, I must also be bad. Anything I said after that would not be trusted. Sadly, the patient will live with the problem. My lesson in her case was that I should have offered a non-mesh option during the consultation and offered her choice after adequately discussing the pros and cons. Had she chosen a non-mesh procedure knowing it was inferior, I would have to honour her choice. There is no room for paternalism if there is no trust by patients. Not offering the non-mesh option because I believed it was inferior was a paternalistic value judgment. I sent her the latest RANZCOG guideline on Sacrocolpopexy, but it will carry little influence. RANZCOG continues to be called to account. In 2022 the Australian Commission on Safety and Quality asked for credentialling statements to limit who can perform sacrocolpopexy procedures.

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#### Election of President for the Thirteenth RANZCOG Council

Following the conduct of the election for President of the Thirteenth RANZCOG Council, and the announcement at the March 2023 Council Meeting, Dr Gillian Gibson is declared the President-Elect for the Thirteenth RANZCOG Council, being from November 2023 until November 2025.

Dr Gibson shall assume the office of President at the conclusion of the 2023 Annual General Meeting and until then, shall be known as the President-Elect.

The RANZCOG Board and Council congratulates Dr Gillian Gibson on her election.





#### Election of RANZCOG Board for the Thirteenth RANZCOG Council

Following the conduct of the election for the RANZCOG Board for the Vice-President and Elected Director positions for the Thirteenth RANZCOG Council to take office from November 2023 to November 2025, the following nominees have been elected to these positions:

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- Dr Susan Fleming,\* Vice-President who shall reside in New Zealand
- Dr Nisha Khot, + Vice-President who shall reside in Australia
- A/Prof Boon Lim,<sup>+</sup> Vice-President who shall reside in Australia or New Zealand
- Dr Michael Rasmussen,\* Elected Director
- Dr John Regan,\* Elected Director
- Dr Jared Watts,\* Elected Director •

\*No ballot required, as the number of nominations did not exceed the number of vacancies \*Ballot required, as the number of nominations exceeded the number of vacancies

The RANZCOG Board and Council congratulates the successful nominees on their election.



6/2023 6:00:00 PN

In 2023 the Prosthesis List Committee has asked RANZCOG for comparative and cost data on the various continence procedures, and the ACSQHC want a model of care for sacrocolpopexy. In New Zealand, a petition is being brought to parliament requesting a suspension of midurethral slings. Furthermore, NZ gynaecologists wanting to perform incontinence and some pelvic floor surgeries (not just mesh cases) are currently undergoing a rigorous credentialling processes, which stand to limit their ability to perform some surgeries if they do not meet the criteria. What is happening in New Zealand could easily happen in Australia.

#### So where did we go wrong?

The health regulatory system allowed the proliferation of mesh products which were rapidly adopted by surgeons internationally. Why? Because for MUS they offered a simple, elegant, effective, and minimally invasive solution to a common problem. This happened organically without clinical trial evidence, ongoing surveillance systems, formal training programs, or prospective data collection and review (clinical registries). Adverse outcomes were uncommon and sometimes occurred sometime after surgery, meaning the operating surgeon was often unaware of problems or did not connect the symptoms with the original surgery.

### What have we learnt from our experience with mesh?

We now know that high-quality research is just as important for surgical innovation as it is for other treatments. We have re-learnt the importance of surgical data and follow up in uncovering problems. We better understand the importance of surgical training for new procedures, the importance of patient selection, communication skills and detailed broad-based, procedure specific informed consent. These lessons need to be applied to all novel treatments in the field of urogynecology and beyond.

#### What should we do now?

1. Prospective documentation of surgery. would advise that every RANZCOG member that sees and treats women with urinary and pelvic organ prolapse begin documenting every single case they see. I would recommend making a database, including evidence of the first treatment steps such as whether a pessary was trialled. It is important that our critics understand that we see the vast majority of women with pelvic floor disorders, and that a majority of women receive conservative care, and that we are not operating on every woman we see. We treat these conditions holistically, not just surgically. By keeping our data, each of us will demonstrate that as gynaecologists we are champions for pelvic floor problems. This is a tall ask, but our specialty is encountering hostile times. The denominator will be important when we show we treat 50% of our patients conservatively, and might insert mesh in, perhaps 1 or 2 of 10 of the women we saw, and that we performed non-mesh vaginal surgical procedures in 2 or 3 of those 10 women. Trainees should do the same, and keep that data forever, because evidence of

training is fundamental in protecting ourselves against future challenges. It's tedious but it is worthwhile.

- Record outcomes including PROMs and report problems. I also suggest that PROM measures be routinely used for all your procedures at six weeks and six months. Log these on a database also. For those without their own established databases. The Australasian Pelvic Floor Procedures Registry was initiated in January 2021 and holds data reported by clinicians across Australia that contains validated PROMs and is accessible to the TGA for early detection of problems with particular meshes or grafts. In this way, my rare complication and another surgeon's rare complication can be mapped, and the detection of problematic products can be identified earlier to keep our patients safe. If as surgeons we are promptly made aware, action might then be taken by our own specialty, rather than social media, government, and law courts. Go to www.apfpr.org to register. Furthermore, read the ACSQHC guidelines on credentialling for SUI and sacrocolpopexy. A model of care for sacrocolpopexy is also under way.
- Discuss and document all options. Offering 3. pelvic floor muscle training options and vaginal devices for continence or prolapse is a routine part of the education and treatment of women with pelvic floor dysfunction. Devices for continence (such as continence dishes and contiform devices) and for prolapse (rings, shaatz, cubes, gellhorns etc) should be routinely considered and offered. It is insufficient to offer only ring pessaries. My practice is stocked with a range of devices. An alternative would be to refer to a clinician near you that can provide and fit these devices if women are inclined. All of us who treat pelvic floor conditions understand that surgical options should be considered once conservative approaches have been explored and are problematic, or if women chose not to use vaginal devices. These options should be documented. If surgery is needed, even if you think a mesh option is best, make sure nonmesh options are discussed. Our patients should be given options and choices.
- 4. Expand your surgical skillset. Pelvic floor surgeons need to either expand their skillset to include minimally invasive procedures such as laparoscopic burch colposuspension/ or pectopexy, and make sure these options are offered. Referral to colleagues that do procedures that we can't might be difficult for the ego, but it is necessary if our specialty is to rebuild its reputation in the public eye.
- 5. Detailed standardised consent. If a woman chooses a mesh procedure, it is important to sit and read pre-written standardised information about the procedure with the patient. A consent should include the word 'mesh' so that there is no doubt that the patient understands this issue. If it is off label, this too should be written on the consent. Provide the IFU (information for use) document to the patient, and the patient batch number after the procedure. In the near future, unique device identifier labels will be developed for every device.

# RANZCOG Annual Scientific Meeting 2023

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# QCA



The postpartum bladder is commonly afflicted by injury and infection, and the associated shortand long-term sequelae can be debilitating. Our understanding of the normal, and abnormal, postpartum bladder is unfortunately incomplete<sup>1.2</sup> and thus the diagnosis and management of early postpartum bladder issues, such as urinary retention, urinary tract infection (UTI) and urinary incontinence, can be complex.

There are no universal diagnostic criteria for postpartum urinary retention (PUR).<sup>1</sup> Therefore, institution-specific clinical guidelines vary greatly, and poor compliance with these guidelines adds complexity.<sup>3</sup> Systematic reviews and meta-analyses estimate the incidence of PUR following vaginal delivery to be between 10–14%.<sup>14</sup> The majority of PUR is covert or asymptomatic; there is spontaneous voiding but an unacceptably high post-void residual (PVR) volume. The remaining cases are overt urinary retention (there is no spontaneous voiding), with reporting at a lower rate of around 5%.<sup>15</sup>

The incidence of postpartum UTI, especially following catheterisation, is also unclear due to varying definitions of UTI (e.g., the data may include cases where a patient was treated for UTI, but not necessarily where there was a microbiological diagnosis) and selection bias in retrospective cohorts. The majority of postpartum UTIs are associated with intrapartum catheterisation, with incidences of 3.5–30% appearing in the literature, and no reduction in rates when intermittent catheterisation is used compared to continuous catheterisation.<sup>67</sup>

The incidence of urinary incontinence at three months postpartum, including all birth modes, is estimated to be approximately 30%.<sup>8</sup> It is not possible to determine what percentage of bladder overstretch injuries from PUR contributes to this. Nor is it possible to determine rates of long-term sequelae (chronic retention, hypo-contractile bladder, incontinence and infection) in this population. Extrapolation from other populations and first principles indicates that the less severe the overstretch injury in magnitude, frequency and duration, the less likely are long term consequences.<sup>2</sup> Stretch injuries of over 1,000 mL appear to carry these risks, with worse long-term voiding associated with larger volumes of retention and overstretch.<sup>9</sup> For the broader O&G Magazine readership, balanced answers to those curly-yet-common questions in obstetrics and gynaecology.

#### Dr Andrea Atkinson MBBS DTMH Adv DRANZCOG Urogynaecology Fellow, King Edward Memorial Hospital

Dr Sally Ellis Wilkinson BSC BA MD

Dr Nicolas Tsokos MBBS FRANZCOG CU Consultant Urogynaecologist, King Edward Memorial Hospital

Junior doctors and hospital medical officers (HMOs) are usually at the front-line of responding to queries regarding bladder care in the postpartum patient, and for many of the reasons above, this can be a daunting task. The following scenarios drawn from real-life ward calls attempt to answer some practical questions that may arise.

#### **Real-life scenario**

Pager, 4:55PM: "Mrs U for d/c today, has failed TOV please review re need for IDC/home"

The Pandora's box that is opened by a page like this at the end of the day can be overwhelming for a junior doctor, but hopefully these few practice points will assist.

### Step one: Find your hospital's policy on voiding after surgery or postpartum

Alternatively, the major centres all have policies that are readily available on the internet. These are safe and useful guides that can help to address hospital and patient pressure for discharge, and provide you with steps to take in managing a failed trial of void.<sup>10-14</sup>

There will always be a degree of variability between centres in relation to some of the specifics, so finding your local hospital policy can help to provide consistent advice.

Aspects that may differ between guidelines include:

- Percentage of bladder volume voided to be considered an adequate void (range 50–80%)
- Total volume voided to be considered adequate void (range 150–300 mL)
- Amount of residual volume considered to be an inadequate void (150–300 mL)
- Amount of time to allow following in-dwelling catheter (IDC) removal postpartum ability to void (range 2–6 hrs)<sup>13</sup>
- Duration of IDC re-insertion depending on residual volume

#### Step two: Determine the reason for catheterisation

This can be important in terms of understanding the potential reasons for inability/ inadequacy of the void. The top three reasons and their relevant considerations are shown in Diagram 1.

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Diagram 1. Summary of reasons for catheterisation and underlying aetiology<sup>10, 15, 16</sup>

If the patient has already had a catheter re-inserted after a failed trial of void 24–48hrs prior, most guidelines would recommend that further early attempts at voiding are not undertaken. The patient may be discharged with an IDC for 5–7 days before re-attempting a trial of void under supervision, or taught clean intermittent self-catheterisation (CISC).

Avoidance of IDC by teaching a patient CISC is an evolving area, with some studies showing promising results<sup>17</sup>. However, this needs to be considered carefully given the multiple complicating factors that may make timed voiding and self-catheterisation difficult for a new parent.

### Step three: Modify any reversible causes that could be impacting on the patient's ability to void

See Table 1 (next page) for a list of factors that can impair bladder function. By addressing these causes, it may be possible for patients to achieve a successful void preventing the need for IDC re-insertion when they undertake their next trial of void.

Note: It is important not to delay bladder emptying while attempting to modify the above, as this can result in bladder stretch injury, which will further compound urinary retention and voiding dysfunction.

#### **Real-life scenario**

The patient is worried about having a catheter reinserted if she fails her trial of void again. Can we just clamp the IDC and see if she has the urge to void?

The evidence would suggest that this process of clamping an IDC as a test of voiding urge is not effective. A Cochrane review determined that there was a greater incidence of UTIs, and delay to normal voiding in the clamp-and-release-group as opposed to the catheter removal group.<sup>18</sup>



#### **Real-life scenario**

The patient can void but has reduced sensation. What now?

First, exclude urinary retention. Check the patient's trial of void (if they have completed one) and continue to record voided volumes and PVR volumes. Refer the patient for in-patient physiotherapy review, which may include behaviour modification and bladder training, as well as exercises to re-establish biofeedback and strengthen the pelvic floor.<sup>19</sup> Bladder training includes timed voids, usually every four hours, to prevent the bladder from becoming overfilled, as well as a diary detailing fluid input and bladder outputs. Refer the patient to outpatient physiotherapy and/or a specialist continence nurse for post discharge follow-up.

#### **Real-life scenario**

Pager: "Patient for discharge with IDC? need for antibiotics"

Although an IDC duration of >24hrs is significantly associated with the development of bacteriuria, it remains unclear whether prophylactic antibiotics should be instituted as part of management for patients who require short-term IDC drainage.<sup>20</sup> The benefit appears to be in a reduction in subsequent bacterial growth of catheter urine specimens, but few studies on this topic report on the main risks, which include adverse reactions to antibiotics and selection/ development of resistant bacterial strains and complicated infections.<sup>21</sup>

At present, Therapeutic Guidelines Australia recommends against antibiotic prophylaxis to prevent catheter-associated UTIs and often microbiology laboratories will not report bacteria detected from catheter urine specimens without  $( \mathbf{ } )$ 

	Examples	Management
Pain	Pain at surgical sites, especially lower transverse abdominal incisions limiting mobility and positioning to allow voiding Peri-urethral or vulval trauma causing dysuria	Target management to specific pain e.g., Reviewing systemic analgesia versus urinary alkalinisation to prevent dysuria
Opioid analgesia	Degree of adverse effects of opioid medications such as urinary retention and constipation is variable	Review analgesia and consider non- opioid options, such as perineal ice packs
Constipation	This can be exacerbated by immobility, opioid analgesia or dyschezia from haemorrhoids or sutures near the peri- anal skin	Actively manage constipation with both oral and rectal treatments as appropriate prior to next trial of void
Compression	Intrabdominal collections Vaginal wall haematomas	Exclude major collections or await improvement of oedema prior to further trial of void

Table 1. Factors contributing to ongoing urinary retention.

further information, given the bacterial colonisation rate of an IDC being 3–7% per day.  $^{\rm 20}$ 

To prevent catheter-associated infections:22

- Consider alternatives including CISC
- Ensure aseptic technique with insertion
- Review indication and duration of IDC before discharge

#### **Real-life scenario**

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But how will I know if it is in fact a UTI if I cannot test a catheter urine specimen?

It remains important to diagnose true UTIs in the presence of an in-dwelling catheter, as persistence of true infection can result in delayed recovery of bladder functioning and systemic illness. Prior to urinary catheter re-insertion after failed trial of void, a UTI may be suspected based on symptoms of suprapubic pain, flank pain, fever or dysuria. If this is the case, the patient should be asked to provide a urine specimen, even if only a small amount is able to be voided.

If the patient cannot void at all, a 'clean-catch' specimen can be collected at the time of new catheter re-insertion and this can be sent for routine analysis.<sup>23</sup> Alternatively, if further information is provided on the request form for a catheter specimen, this will aid in interpretation by the microbiologist to provide relevant results, rather than the specimen being rejected.

#### Conclusion

Postpartum bladder issues are common, and the diagnosis and management of these conditions are limited by our incomplete understanding on this topic. However, paying attention to specific risk factors associated with PUR, UTI and urinary incontinence, as well as careful history taking and examination, can empower clinicians (and especially junior doctors). Ultimately, this results in better care for the postpartum bladder and early identification of potential issues, allowing involvement of physiotherapy and continence nurses to aid in management.

#### **Points to Remember**

- Identify patients at risk of postpartum urinary retention and ensure a formal trial of void is undertaken postpartum or following IDC removal.
- Have a low threshold for assessing with a bladder scan or in-out catheter to determine post void residual (<150 mL is normal, as a general cut-off).
- Initiate management immediately to avoid repeating any overstretch injury once identified (volumes of ≥ 1000 mL with IDC insertion following inability to void).

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# Dr May Aung

### Leaving an outstanding legacy for the Cook Islands

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Will Poole RANZCOG Communications Advisor

After more than 25 years of outstanding practice in the Cook Islands, Dr May Aung will retire in June. We spoke to Dr Aung about her career in healthcare and about practicing O&G in a remote and challenging Pacific location.

Dr May Aung moved to the Cook Islands in 1989, joining her husband Zaw Aung, who had been working there as a United Nations volunteer. They were initially based in Mangaia, the southern-most island. A general practitioner in Myanmar since 1975, May soon found herself working with patients there, despite not holding any official appointment.

In 1993 she took a position on Aitutaki, the secondlargest island, working there until 2001, when she was asked to move to the largest island Rarotonga, to work more closely with the Ministry of Health. May has been in Rarotonga since then, serving as head of her department from 2005, and eventually becoming Director of Hospital Health Services in 2017.

Obstetrics and gynaecology had always been an area of interest for May, ever since she was attached to an O&G department after completing her internship. However, in the Cook Islands it became increasingly central to her work, particularly given that she was the only female doctor in the country for much of her time there.

"I wanted to do O&G all the time," May recalls. "But when I got to the Cook Islands, it pushed me more because I felt responsible as the only woman doctor in the country. And the women felt very comfortable with me looking after them."

In 2004, May became the first non-Cook Islander to be awarded a scholarship through the New Zealand Scholarship Scheme, completing a Diploma in Gynaecology and Obstetrics at Fiji National University (FNU). There was the option for further study, but May was facing too many demands back in the Cook Islands.

"I was qualified to continue my Masters, and FNU waited for me for five years," says May. "But sadly, the Cook Islands wouldn't let me go back because there was no-one to carry on the services in the country. They wouldn't let me leave to continue my studies because there was no-one to work."

And there has indeed been a lot of work. In Aitutaki, May oversaw around 50 deliveries each year; after moving to Rarotonga, her team was dealing with 250 to 300 births annually. May has been on call 24/7, attending every delivery, and she speaks with pride about the fact the Cook Islands has maintained a zero maternal mortality rate since 1995.

Alongside countless successful births, there have been other achievements along the way. May cites a mammogram screening program that she is currently overseeing, which follows on from a highly successful overhaul of the Islands' cervical screening set-up.

"When I started, we were using conventional smears on glass slides," she explains. "But now we're doing HPV screening, which one only has to do every five years, and this improves our screening uptake. How did I get to that? I went to do a presentation in March 2019 in Auckland, and I met the New South Wales Australian team, and they supported me to progress to cervical cancer screening by HPV."

These achievements have taken place amid the considerable challenges of operating in the Cook Islands. The country consists of 15 islands spread across 2.2 million square kilometres of ocean, with transport links extremely limited, especially among the more remote northern islands. Staffing is another issue, with a shortage of midwives on many of the islands.

May describes one case of a woman with a ruptured ectopic pregnancy in Rakahanga, an island with no airstrip, necessitating a three-hour boat trip to receive treatment. In another case, May had to fly to Pukapuka to perform an emergency Caesarean. She took a limited team, as well as two drums of aviation fuel because there was none on the island for the return flight.

Challenges such as these are a constant for May: "Currently I have four pregnant mothers who are due this week. I've been trying to transfer them, but there is no fuel for the flight to go up, and one flight is down because of a brake problem. And my heart is very heavy because one is a gravida nine mother in Pukapuka."



Dr May Aung has been treating patients in the Cook Islands for more than 25 years.



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These challenges inevitably place an intense emotional burden on May: "It is very lonely because you are the only person practicing O&G in the country. You are 24/7 on call, and I never failed to attend one delivery in my career. And sometimes, you are so tired, but you still have to continue your clinics."

Nonetheless, May draws great satisfaction from her work: "Because you have saved many lives, and the appreciation and gratitude from the families, I think it's worth all the stress and the hard work. The children I delivered in Aitutaki and in Rarotonga, they're now having babies, and I have delivered them. And when I go on the road, they are calling me 'Dr May, Dr May', and they say 'Oh, my mother told us you delivered me.' It really makes me happy."

For women O&G specialists considering working in the Pacific region, May advises: "It is a very hard and challenging career, but it is worth it because you are saving lives and looking after not only one patient, but the whole family. I've made lots of friends and I was able to help people to improve their health and change their family status through doing O&G."

Recently, May has been heavily involved in a project quite removed from her usual O&G practice. Since late 2020, she has been instrumental in the rollout of the COVID-19 vaccine in the Cook Islands, and as she recounts it, her participation was unexpected.

"I just got pulled into this thing," she explains. "Over Christmas 2020, the then-Secretary of Health decided to leave suddenly. I was told on the 24th, and the new secretary was a non-medical person. So, I was dragged along to Cabinet meetings with this new secretary, and the Prime Minister asked us, 'Have you finished your deployment and COVID vaccination plan?' And I had no knowledge. This is not my area; this is a public health area."

Despite this, May agreed to help. She started to ask questions and gather information, reaching out to bodies such as UNICEF, the World Health Organization (WHO) and the New Zealand Ministry of Health for support. By Easter 2021, May and her team had put together a plan.

"We started vaccinations on 17 May on Rarotonga," she continues. "And we've been going to the outer islands to give the first dose, second dose and the booster. We went around each village talking to the people before we gave the immunisation. So, the uptake was very good. We've covered 98% of the 12plus population in Cook Islands. With the five to 11 age group, we are around about 82%."

It's an astonishing success that comfortably surpasses the efforts of many far wealthier nations – Australia and New Zealand included. But May is characteristically humble.

"This was not only the Ministry of Health effort – it was a community effort," she says. "We were supported by all other agencies and ministries, and the traditional leaders, the church leaders, the youth, the NGOs like the Red Cross. So, I think it is a united achievement by all the people of the Cook Islands."

May's remarkable work in the vaccine rollout serves to enhance an already extraordinary legacy during her time in the Cook Islands – one that her colleagues keenly endorse. Dr Martin Sowter is one such colleague who has worked closely with May, regularly visiting the Cook Islands for nearly 20 years to mentor colleagues and build O&G capacity there. He is also an obstetrician and gynaecologist based in Auckland, and a member of RANZCOG's Global Health Committee.

"Every doctor encounters a couple of colleagues over the course of a career that they regard as personal 'superheroes' – an embodiment of everything that makes a great doctor," says Martin. "For me, May has been one of those people. Her quiet, determined, meticulous and completely caring approach to her work and her patients has kept the women of the Cook Islands safe from the start of their pregnancies through to old age. In her role as the nation's only

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Dr Aung was instrumental in the Cook Islands' hugely successful COVID-19 vaccination program

O&G specialist, she's had a workload and range of responsibilities that most Australian and New Zealand colleagues would find crushing.

"More recently as the director of hospital services, she has been a master at making politicians believe that a good idea was their idea and then 'getting stuff done'. I still fondly remember meeting her in Auckland a few weeks before their COVID-19 vaccine rollout, when the New Zealand program was still bogged down by committees and dithering. New Zealand experts were worried about cold chains, vaccine supplies, and wondering if the Cook Islands could really run the vaccination program.

"May and her team just threw everything at the project and rolled the program out across the nation's 13 inhabited islands in weeks, with possibly the highest and fastest vaccine uptake in the world. May is far too modest to take any credit for this but she was absolutely crucial to the success of their COVID vaccination campaign."

Dr Amanda Noovao-Hill grew up in the Cook Islands. Now based in Queensland, she is currently Head of Secretariat for the Pacific Society for Reproductive Health (PSRH), of which May is a member. Last year May and Amanda secured funding for two midwifery leaders and a medical officer to represent the Cook Islands at last year's PSRH conference in Samoa – though unfortunately, due to travel logistics and COVID, the three clinicians were unable to attend.

In her capacity as Clinical Associate Professor in  ${\rm O} \& {\rm G}$  at the FNU's College of Medicine, Nursing and Health

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Sciences, and as a former RANZCOG Global Health Committee member, Amanda often provided support for May in efforts to strengthen O&G service and training in the Cook Islands.

Strategies implemented by May and Amanda included: audio and video conferencing with the Rarotonga O&G Unit and the outer islands clinical teams providing advice and support; enabling onsite training of a local junior doctor and a postgraduate trainee; assisting with recruitment of regional O&G support; and facilitating training opportunities for other health-related specialties.

"Thank you May for your love, sacrifice and service to the Cook Islands, and your professional collegiality to the regional academic institutions and our professional societies," says Amanda. "Kia manuia I toou akangaroianga. Te Atua te aroa."

Finally, May is on the verge of stepping away from O&G. She first broached the idea of retirement three years ago, but the Ministry kept persuading her to stay on. However, May is now adamant she will not extend any further. It's time for a well-earned rest.

"I don't think I will do anything," she laughs. "I will not be doing anything in regard to medicine. I will just enjoy life. I really don't know what to do yet – maybe some planting flowers, or fabric painting, which I enjoy very much."

And as for the Cook Islands?

"I will stay for a while, but we will definitely have to go back to Myanmar at some stage. I have family there. I have my house. So, I will have to leave the Cook Islands, which will be sad. But I have been trying to prepare myself."



Dr May Aung with her husband Dr Zaw Aung and Dr Martin Sowter.

### Do you have experience working or volunteering in low- to middle-income countries?

#### Share your story in O&G Magazine

RANZCOG is committed to improving the health of women and their families, including in the Pacific region.

The College is seeking contributions for O&G Magazine about global women's health. Articles and opinion pieces that highlight women's health issues or initiatives in low- to middle-income countries are appreciated.

Don't have time to prepare a written contribution? We can interview you and write the article for you.

Contributions are welcome from all College members.

For more information about contributing to O&G Magazine, go to: www.ogmagazine.org.au/contribute





# Improving rural birth outcomes in PNG

A program incentivising supervised rural births

Prof Glen Mola FRANZCOG

Many of us who get towards the end of our O&G career pause to reflect on achievements and endof-career direction and plans. In 2013, I decided to give up after-hours private practice and sell my last interests in a private hospital I had built in the 1980s and 90s. Instead, I chose to focus on training the next generation of doctors, and other strategies to improve maternal and newborn outcomes across Papua New Guinea (PNG).

In a low-income country like PNG, the major impact on maternal and newborn care outcomes is to be made by providing quality midwifery and newborn care near where women live: 85% of people in PNG live in rural areas.

In 2012, I teamed up with the late Dr Lahi Geita – a colleague in the National Department of Health – to train our basic rural nurse, known as a community health worker (CHW), to provide quality maternal and newborn care. A pilot training program at Mt Hagen Base Hospital involved six months on-the-job, inservice training, with strict selection criteria to ensure that the graduates returned to their rural health facility after completing training.

To date, there have now been over 20 such trainings conducted in groups of 7–10 CHWs, in 14 provincial hospitals around PNG. In total, 320 CHWs have been upskilled in this program to provide quality maternal and newborn care in the context of rural PNG.

The O&G unit at the Port Moresby General Hospital (PMGH) in the national capital, where I spend 90% of my professional time, recorded an increase in its numbers of annual births of about 10% between 1978 and 2016.<sup>1</sup> In 2016 we were offered some reproductive health assistance by the DAK Foundation, an Australian philanthropic trust. My professional colleagues (midwifery and medical) and I decided that the best way we could use this support was to set up an immediate postpartum familyplanning implant program. Since 2017, the numbers of women presenting to the PMGH labour ward for supervised birthing care has plateaued at around 14,000. If it had kept on rising by 10% per year (as occurred between 1970 and 2016), we would by now be overwhelmed by more than 25,000 women per year seeking supervised birthing care in a facility designed to provide care for 10,000 (as there is no other public maternity facility in the national capital, Port Moresby).

PMGH O&G division also offers immediate postpartum tubal ligation and vasectomy services, and about 1,800 couples avail themselves of this family-planning completion strategy, annually. Along with the 5,000 implants per year we now provide, this means that almost half of women birthing at PMGH return home with an effective method of long-term contraception. We estimate that less than 10% of the remainder subsequently attend city family-planning clinics to start a modern method of contraception.

More than 90% of women who go on to deliver at PMGH receive regular antenatal care in Port Moresby's clinics – including 5,000 per year who attend the public hospital clinic. These women receive some of the best maternity care in the world, despite many human and resource constraints. The perinatal mortality rate (PMR) among 'booked'

![](_page_54_Picture_11.jpeg)

Prof Mola with a rural mother and an upskilled nurse presenting a baby bundle

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mothers at PMGH maternity is generally less than half that of similar-sized public maternity units in other low- or middle-income countries. The maternal mortality ratio is similarly low.

For booked mothers at PMGH:

- the PMR is less than 20/1.000 births
- the MMR is about 50/100,000 live births

This is achieved with possibly the lowest intervention rates in the world, with a caesarean section rate of 5%, assisted vaginal delivery rate of 5%, and induction of labour rate of 5%.<sup>2</sup>

On the other hand, the supervised birth proportion for the rest of PNG is shamefully low, at less than 40%, and has remained static at this level for more than 20 years. Women who are unable to get a supervised birth have a ten-fold risk of dying in childbirth. Their babies have a three-fold risk of death, and also a higher rate of non-fatal birth trauma, often with life-long consequences (see Table 1).

### Table 1. Mortality rates in PNG by place of delivery (PNG DHS 2016).

Facility	MMR/100,000	PMR/1,000
Hospital	100	30-40
Health centre	200-300	40-50
At home, with no ability to refer	800-900	100

To improve this, it is critical to increase the proportion of women choosing to deliver at rural health facilities, rather than remaining in their rural village homes. Of the 360,000 births annually in PNG:

- 30% are supervised in 22 provincial hospitals (including PMGH)
- 10% occur in approximately 800 rural health facilities (equating to less than one birth per week in most of them)

The provincial hospitals are overcrowded, and the rural health facilities are very under-utilised. Clearly, if we are to improve the proportion of women accessing supervised birth services, more women need to utilise the rural health facilities near their homes.

About 10 years ago I decided that my retirement would be more meaningful if we could achieve supervised birthing services for the rural majority of women who are currently at risk of morbid outcomes for both themselves and their newborns.

Over the past 10 years, these trainings and rural health centre upgrades have been made possible with funding from various support agencies, including church agency health services and nongovernment organisations (NGOs), such as DAK Foundation, Soroptimists International, and the Mola Foundation. Government and United Nations agencies have also helped, including AusAid, United Nations Population Fund (UNPF) and UNICEF.

Local provincial health authorities in PNG have also contributed significantly by helping to select suitable CHWs for training, and by paying their salaries for six months during the in-service training program.

![](_page_55_Picture_17.jpeg)

#### Setting up for success

To encourage women to come to their rural health facility, there needs to be:

- 1. Well-trained health workers to provide quality maternal and newborn care;
- Rural facilities with the capacity to provide quality care for birthing women 24 hours per day.

![](_page_55_Picture_22.jpeg)

Crowd for the opening of the new health centre birthing unit in Wangoi, PNG.

Initially, we hoped that decent facilities and well-trained staff would be sufficient to alter the behaviour of women and their families; to swap their traditional view of home births for a journey to their local rural health facility for a safer supervised birth. Initially, this did not happen; most of rural health facilities remained under-used.

So, in 2019, I decided that we should try an additional motivational strategy that was based on an idea pioneered in Finland and Cambodia to incentivise rural supervised birth. The latter country managed to increase the supervised birth proportion from about 35% to 75% over five years in the late 1990s, by incentivising supervised birth in rural areas. Additionally, a pilot incentivisation program underway since 2009 in Milne Bay province (PNG) had doubled supervised birth numbers in 15 participating rural health facilities.<sup>3</sup>

Also in 2019, we initiated a 'baby box' program, complemented with food supplies, to eight rural health facilities in Simbu province in the highlands of PNG. The baby box contains everything that a family might need, all wrapped in large plastic baby bath, including:

- Baby: nappies, pins, blanket, booties, vest, towel
- Mother: sanitary pads, soap, umbrella, new sarong
- Father: a file to sharpen an axe, and a new spade

Also supplied is brown rice, tinned tuna, and coins for the nurse to purchase greens in the local market for the women and their accompanying family – usually the husband and last-born child. Without food to eat, pregnant women are unable to stay around the 'mama waiting houses' in the rural health facilities for the onset of labour.

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This program has now been running for three years, and in this time, most of the participating rural health facilities have seen a more than doubling in the numbers of women attending for supervised birth.

Epidemiologically, it is estimated that one woman's life is saved for every additional 150 women who come for supervised birth, and one newborn is saved for every 20 additional women who come for supervised birth in their local rural health centre.

Over the three years of this program's life, it is estimated that incentivisation for this improved level of delivery care has averted 20 maternal deaths, and 150 newborns lives have been saved. These benefits do not include improvements in morbidity, increased numbers of women who accept immediate postpartum contraceptive implants, and referral to the provincial hospital for postpartum tubal ligation.

The cost of this program is modest: about \$3,000 per rural health facility each year, depending upon the numbers of supervised births in the facility. Support of eight rural health facilities enables an additional 1,000 women per year to have a facility-supervised birth by a health professional. I am hoping that we can extend this work to other provinces of PNG soon.

In the long run, improved survival of mothers and children, especially if accompanied by a further reduction in the birth rate, should help to trigger feedbacks that improve wellbeing and prosperity in PNG. These are benefits that Maurice King (in the 1960s, the man who was responsible for changing the world public health paradigm to a focus on 'community medicine') and his colleagues and supporters have long alluded to.4,5

![](_page_56_Picture_6.jpeg)

Prof Mola and Dr Barry Kirby opening the Wangoi health centre birthing unit in 2019.

DAK Foundation: https://dak.org.au Soroptimists International: www.soroptimistinternational.org Mola Foundation: www.perpetual.com.au

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# **RANZCOG Mentoring Program**

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RANZCOG will be piloting a mentoring program for a small cohort of Fellows, new Fellows and advanced trainees. RANZCOG has partnered with an online specialist mentoring platform to facilitate the RANZCOG mentoring program.

A mentoring program can provide mentors with a sense of fulfilment from seeing others develop, strengthen their leadership and interpersonal skills, and is an opportunity to share their professional experience.

Mentees can benefit from the program in many ways, including support and guidance outside their traditional supervisory settings, and having a trusted person with whom to discuss uncertainty, new ideas and feedback.

The RANZCOG Mentoring Program will launch in February 2023 and run through to February 2024.

For more information, please email **mentoring@ranzcog.edu.au** 

![](_page_58_Picture_6.jpeg)

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